PLASTIC SURGICAL ARTS
The Beauty of Transformation

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DATE OF REQUEST: _____

PATIENT'S NAME:_ DATE OF BIRTH: _____ _

ADDRESS: _____

CITY/STATE/ZIP CODE: _____ _

HOME PHONE: _____ WORK PHONE: _____ _

CIRCLE TO OR FROM

I AUTHORIZE PLASTIC SURGICAL ARTS TO RELEASE INFORMATION :

OR

I AUTHORIZE PLASTIC SURGICAL ARTS TO OBTAIN INFORMATION FROM;

_____

NAME OF PROVIDER OR FACILITY

_____

ADDRESS

_____

CITY, STATE, ZIP CODE

_____

PHONE AND/OR FAX# (INCLUDE AREA CODE)

REQUESTED INFORMATION: _____ _

PURPOSE OF REQUEST: _____ _

AUTHORIZATION VALID FOR: (CHECK ONE)

__ THIIS REQUEST ONLY.
__ ONE YEAR FROM THE DATE OF THIS AUTHORIZATION OR _____ . (INSERT DATE). THIS AUTHORIZATION APPLIES TO THE RECORDS OF THE TREATMENT RECEIVED ON OR PRIOR TO THE DATE OF THIS AUTHORIZATION.

SIGNATURE OF PATIENT OR REPRESENTATIVE: _____ _

DATE: _____ _

RELATIONSHIP TO PATIENT (IF REQUESTER IS NOT THE PATIENT): _____ _

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