



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 T O 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)

THIS 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): _____