PLASTIC SURGERY CENTER

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MEDICAL RECORDS RELEASE FORM

Patient's full name:_____ Previous name:_____

Date of birth:_____

I hereby authorize The Plastic Surgery Center to (RELEASE / RECEIVE) information to the following:

_____
Full name

_____
Address

_____
City State Zip

Phone #_____ Fax#_____

This form will authorize you to provide a copy, summary, or narrative of my medical records as indicated by the check mark(s) below or to otherwise release confidential information.

At this time I am requesting the following:

_____ Complete record

_____ Records of care from _____ to _____ only

_____ Records of care concerning the following condition(s):

_____

The reasons or purposes for this release of information are:

_____

I understand that you will provide this information within 5-7 business days from receipt of request.

Signed: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

Would you like to: Pick up records, have them faxed, or mailed when completed?
_____