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MEDICAL RECORDS RELEASE FORM

**Please allow 3-5 business days

Patient's full name:_____ Previous name:_____

Date of birth:_____ Phone #:_____

I hereby authorize The Plastic Surgery Center to < receive / release> information from/to the following:
(Please circle)

_____
Full name

_____
Address

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 to release confidential information.

At this time I am requesting the following:

_____ Complete record

_____ Records of care from dates _____ to _____ only

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

_____

The reasons or purposes for this release of information are:

_____

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

Printed name: _____

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