PLASTIC SURGERY

MEDICAL RECORDS RELEASE

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the release of my medical records as described below:

Records to be Released (check all that apply):

□ Complete medical record
□ Treatment notes
□ Imaging / X-rays
□ Billing records
□ Other (specify): _____

Release Records FROM:

Name/Facility: _____ Phone: _____ Fax: _____

Address: _____

Release Records TO:

Name/Facility: _____ Phone: _____ Fax: _____

Address: _____

PURPOSE OF RELEASE

□ Continuity of care
□ Personal use
□ Insurance
□ Legal
□ Other: _____

METHOD OF DELIVERY

□ Mail
□ Fax
□ Email (I understand email may not be secure)
□ In-person pickup
□ Secure digital delivery (patient portal or encrypted link)

AUTHORIZATION & ACKNOWLEDGMENT

I understand that:

- This authorization is voluntary and I may revoke it at any time by submitting a written request to the releasing provider.
- Revocation does not affect records already released.
- Released information may no longer be protected by HIPAA if sent to a non-covered entity.
- Unless otherwise specified, this authorization expires 1 year from the date signed.

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

Signature: _____ Printed Name: _____

Relationship to Patient (if applicable): _____ Date:_____