AESTHETIC SURGERY ASSOCIATES

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Patient: _____

Date of Birth: _____ Phone Number: _____

This authorization will not be accepted unless all items are completed. The information being disclosed may include HIV/AIDs, Drug/Alcohol Abuse & Mental Health data. This document authorizes release of information entered into my medical record prior to or within 12 months after the date of my signature.

☐ Release Medical Records **To:** ☐ Receive Medical Records **From:**

_____

(Name of Authorized Person, Agency, Institution or Other)

_____

(Street Address)

_____

(City) (State) (Zip Code) (Phone #)

Release/Receive Records:

☐ Complete Medical History

Or Please check the boxes of what records you would like:

☐ Operative Reports ☐ Implant Info. ☐ Insurance Info.

☐ Pathology Reports ☐ Office Notes ☐ Photos

☐ Lab Work ☐ Billing Records

☐ Date Specific – From: _____ To: _____

☐ Other: _____

Records To Be:

☐ Faxed to: _____

☐ Picked Up By Patient ☐ Publish to Patient Portal

☐ Mailed (Additional Fees Apply)

Reason for Request: _____

This consent is subject to revocation at any time except to the extent that the person who is making the disclosure has already taken action in reliance on it. If you wish to revoke this authorization, you must do so in writing to the address at the top of this form. If not previously revoked, this consent will terminate one year from the date of signature. I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated herein.

_____ _____

Signature of Patient or Representative Date

_____

Relationship if signed by other than Patient