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Plastic & Reconstructive Surgery
Hand Surgery

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Authorization for Release of Information

1. I hereby authorize _____ to release the following for:
(Name of Office/Clinic)

(Patient Name)

(Address)

(SSN)

(Date of Birth)

Covering the dates of care from _____ to _____.

2. Information to be released:

_____ Copy of complete health record

_____ Excluding information related to HIV testing/Mental Illness/Drug/Alcohol Abuse

_____ History and Physical

_____ Other _____

3. Information is to be released to: _____

Address for mailing _____

Method via US Mail. Send \$5.00 to address above. Records mailed after receipt of check.

4. Purpose of disclosure: _____

5. I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

6. Specification of the date, event or condition upon which this consent expires.

7. The facility, its employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed: _____
(Patient or representative) (relationship)

Date: _____

(Witness)

Date: _____