ADVANCED FACIALPLASTIC SURGERY CENTER

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Date_____

Patient Name _____ Date of Birth_____

Address _____ City _____ State _____ Zip _____

Other Names Used _____Telephone # _____ Social Security # _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR

- O Continuing Medical Care
- O Workers Compensation
- O Insurance
- O Military
- O Social Security/Disability
- O School
- O Legal Purposes - Name of Attorney(s) _____
- O Other_____
- O Personal Use
- O Medical Research Study

INFORMATION TO BE RELEASED OR ACCESSED

- O All Records
- O History & Physical
- O Device Data
- O All Records Except Billing
- O Office/Progress Reports
- O Laboratory Reports
- O Insurance
- O Operative Reports
- O Consultation Reports
- O Billing
- O Medications
- O Radiology
- O Other_____

METHOD OF DELIVERY

- O Pick Up (You will be notified via telephone when records are ready for pick up.)
- O Mail to Address listed below

Name/Hospital/Contact _____ Office Telephone # _____

Office Address _____ City _____ State _____ Zip _____

ACKNOWLEDGEMENTS

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

_____.

Signature _____ Printed Name _____ Date _____

Patient or Legally Authorized Representative — Patient or Legally Authorized Representative