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Authorization to Release/Request Medical Records

I authorize Biswas Plastic Surgery to **release and/or request** a copy of medical records for:

________________________________ ____________________

Name of Patient Date of Birth

Release/Request Medical Records to/from: (List any Doctors you wish to include)

Name: ___________________________ Name: __________________________

Address: _____________________________ Address: _____________________________

Phone: ___________________ Phone: ___________________

Fax: ___________________ Fax: ___________________

Name: ___________________________ Name: __________________________

Address: _____________________________ Address: _____________________________

Phone: ___________________ Phone: ___________________

Fax: ___________________ Fax: ___________________

Date: _________________

Signature of Patient or Authorized by Law: ____

This document must be signed by the patient or person authorized by law

Due to new HIPAA regulations, we are required to monitor where patient information is being sent and that the intended recipient has received it