THE PLASTIC SURGERY CENTER

MEDICAL RECORDS RELEASE AUTHORIZATION

95 SCRIPPS DRIVE, SACRAMENTO, CA 95825
(916) 929-1833 PHONE (916) 929-6730 FAX

Patient's Name: _____

Date of Birth: _____ Social Security Number: XXXX-XX-_____

Mailing Address: _____

_____

Phone: _____

I hereby authorize_____, M.D. (TPSC doctor's name) to furnish

medical information concerning _____ (patient name) to

_____(recipient of records).

Any and all information may be released, including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records, and/or HIV test results, if any, except as specifically provided below:

_____

_____

This authorization is effective now and will remain in effect until 30 days past the signed date.
I understand that I have the right to receive a copy of this authorization.

Signature: _____ Date: _____

Once completed, please email this authorization directly to medical records at cathy.morse@pscmail.com

If not signed by the patient, please indicate relationship:
(☐) Parent or guardian of minor patient (to the extent minor could not have consented to the care)
(☐) Guardian or conservator of an incompetent patient
(☐) Beneficiary or personal representative of deceased patient
(☐) Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage.