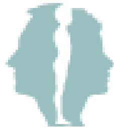

THE PLASTIC SURGERY CENTER

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 ________ (date).

I understand that I have the right to receive a copy of this authorization.

Signature: ______________________________ Date: ______________________

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.