AUSTIN PLASTIC & RECONSTRUCTIVE SURGERY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

I request and authorize _____ to release medical information of the patient named above to Aesthetic and Reconstructive Therapeutics PLLC DBA: Austin Plastic & Reconstructive Surgery.

RELEASE RECORDS TO: Aesthetic and Reconstructive Therapeutics PLLC
DBA: Austin Plastic & Reconstructive Surgery
Christine Fisher, MD, FACS | Tosan Ehanire, MD
2905 San Gabriel St. #100
Austin, TX 78705
Phone: 512-815-0123 Fax: 512-861-6206

RELEASE RECORDS FROM:

Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Dates of Treatment to be Released: _____

Medical records to include: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office.

_____ _____

Signature of Patient Date