Usal Cosmetic Surgery Center

Authorization to Release Medical Records

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

I authorize _____ to release a copy of medical records
Health Care Provider/Hospital or Institution
For

_____ _____
Name of Patient Date of Birth

_____ _____
Social Security Number Other Identifying Information if applicable (other names)

Transmission by facsimile or electronic means authorized to expedite transfer of records.
Release medical records to:

_____
Name

_____
Address

_____
Phone Fax

The information will be used on my behalf for the following purpose (s):

_____

By initialing the spaces below, I authorize the release of the following records, if such exist:

____ Complete all medical record: The recipient understands that the entire record may be large and agrees to pay all reasonable copy charges.
____ All hospital/institution records (includes nursing records/progress notes.

____ Transcribed hospital/institution records (includes surgical reports, history/physical exam, Consultation reports, discharge summary reports).

____ Laboratory Reports

____ Pathology Reports

____ Diagnostic Imaging Reports

____ EKG/ Cardiac Reports

____ Physical/Occupational Therapy Reports

____ Billing Statements

____ Physician Office/Clinical Records

____ Implant Information (including operative report)

____ Photographs

____ HIV/AIDS Records

____ Mental Health Testing

____ Drug/Alcohol Diagnosis, Treatment (Federal Regulation, 42, CFR Part2, Requires a description Of how much and what kind of information is to be disclosed. Provide a specific description on the Back side of the form.)

____ This authorization is limited to the following treatment:_____
_____

____ This authorization is limited to treatment for Workers Compensation injuries of:
_____

_____ _____
Date Signature of Patient or Person Authorized by Law