NORTHSHORE
PLASTIC SURGERY

Benjamin J. Boudreaux, M.D.

Authorization for Release of Information/Medical Records Release

I, _____, DOB: ____/____/_____, SS# _____-_____-_____, hereby authorize Benjamin J. Boudreaux, M. D., to release information to any hospital and/or physician to which I may be referred by this office. In addition, I authorize Benjamin J. Boudreaux, M. D., to request and obtain my medical records from any hospital and/or physicians who have treated me.

Signature:
_____

Printed Name: _____ Date: _____/_____/_____

Relation to patient: _____