Lowe Plastic Surgery (LPS)

Authorization for Release of Patient Information

I, _____

(PLEASE PRINT: Patient's Name & Date of Birth)

Hereby authorize PSDA to send my information to:

_____

Doctor Name (s)

_____

Address (Street, City, State, ZIP) Phone#/ Fax #

Or

Hereby authorize my Physician(s),

_____

Doctor Name (s)

_____

Address (Street, City, State, ZIP) Phone #/Fax

I am requesting a copy of my medical records regarding: _____
For date (s) of Service From:_____To:_____

I understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. This authorization expires six month from the date of signature, unless I specify otherwise or revoke my authorization.

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**

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