Medical Records Release

(Name of Patient)

(Birthdate) (Social Security #)

(Street Address) (City, State, Zip Code)

(Home phone #) (Cell phone #)

Authorizes:

Cape Fear Aesthetics Fayetteville Plastic Surgery

2053 Valleygate Drive, Suite 102

Fayetteville, North Carolina 28304

Release of Records to:

(Name of Records Recipient **IF NOT YOURSELF**)

(Name of Business/Health Care Facility)

(Street Address)

(City, State, Zip Code)

Information to be Released:

___Complete Health Records
___Progress Notes
___Physical
___Visit/Discharge Summary
__Visual Fields
__Photographs
__Radiology/Diagnostic
__Pathology Reports
___Lab Reports
___Consultation
___ Other (Specify)

The purpose of which disclosure is authorized: ____Medical Care ____Insurance _____Legal ____Disability determination **Other (Specify):**

_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

I understand that you will provide this information within 30 business days from receipt of request.

Signature of Patient/Parent: _____ **Date:** _____
(If signed by person other than patient, state relationship and authorization to do so)