Heartland Plastic & Hand Surgery
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 for
Health Care Provider/Hospital or Institution

_____ _____
Name of Patient Other identifying information if applicable (**other names**)

_____ _____ _____
Date of Birth Social Security Number Phone Number

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

Information to be Released From: (please be specific)

_____
Provider Name/Organization

_____ _____
Address Phone Number

_____ _____
City, State, Zip Fax Number

Send Information To: (please be specific)

_____
Provider Name/Organization

_____ _____
Address Phone Number

_____ _____
City, State, Zip Fax Number

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

[ ] Transfer of Care
[ ] Self
[ ] Specialist
[ ] Other (must complete) _____

Information to be Disclosed:

[ ] Complete Record Set
[ ] Medical Records from the last 2 years
[ ] Detailed Billing Statement
[ ] Operative Report(s)
[ ] Pathology Report(s)
[ ] Laboratory Report(s)

[ ] Other: _____

_____ _____ _____
Signature of Patient or Representative Relationship To Patient Date