DIGENIS
PLASTIC SURGERY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/RECORDS

_____	_____	_____
Patient Name	**Date of Birth**	**Social Security Number**

Patient Address: _____

Patient Phone: _____

Select One:

{ } I authorize the physician and/or facility designated below to release my protected health information and provide copies of my medical record for review with examination to **Alexander G. Digenis, MD/Digenis Plastic Surgery Institute, PLLC.**

Name/Facility: _____
Address: _____
Phone/Fax: _____

OR

{ } I authorize **Alexander G. Digenis, MD/Digenis Plastic Surgery Institute, PLLC** to release my protected health information and provide copies of my medical record for review with examination to:

Name/Facility: _____
Address: _____
Phone/Fax: _____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken.

_____	_____
Signature of Patient or Authorized Agent	Date