



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

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