AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Phone #: _____

Patient's Signature: _____

I Authorize: Panhandle Plastic Surgery
1301 S. Coulter
Ste 201 Amarillo, TX 79106
P: 806-350-7929
F: 806-350-7930

To obtain my medical records, photos and operative reports from:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

This authorization expires on _____ or 1 (one) year from the date of this authorization or whichever comes first.

Witness: _____ Date: _____