THE
GEORGIA INSTITUTE
FOR PLASTIC SURGERY

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MEDICAL RECORDS RELEASE FORM

Date _____

I, _____, hereby authorize the release of

records from (Doctor or Office) _____

at (address)_____

to (Doctor or Office) _____

at (address)_____

Information released is to include the diagnosis and records of any treatment

or examination rendered to me during the period from _____

to _____.

Patient name (at the time services rendered): _____

Date of Birth: _____ SS#:_____

_____
Signature of Patient or Guardian

_____
Address

_____
Telephone Number