



Authorization for Release of Medical Information

Date of Request: _____

Patient Name: _____

Date of Birth: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

I authorize Vega Aesthetic & Reconstructive Surgery to:

Release Information to:

Name of Provider or Institution: _____

Address _____

City, State, Zip Code: _____

Phone Number: _____

Fax: _____

Obtain Information from:

Name of Provider or Institution _____

Address _____

City, State, Zip Code: _____

Phone Number: _____

Fax: _____

Purpose of This Request:

- Insurance
- Moving out of area
- Transfer of care
- Specialist consult
- Personal file
- Legal

Records Requested:

- Medical records from last 2 years
- Clinic notes (dates) _____
- Lab results (date) _____
- Pathology results (date) _____
- Radiology/imaging reports _____
- Other (specify) _____

This information is intended for use by Vega Aesthetic & Reconstructive Surgery (VARS) only. I understand that my care is not conditioned on this authorization. I am aware that the records released may contain sensitive information, but release of HIV-related information, mental health or substance abuse information requires additional authorization (DOH-2557 form). This authorization will expire exactly one year from the date below or on _____. I have a right to receive a copy of this authorization. I may revoke this authorization at any time by submitting a written request to VARS. If the recipient of this information is not a healthcare or medical insurance provider covered by privacy regulations, this information could be re-disclosed without being further protected by HIPAA rules. I understand that I may be charged for copies provided. There is no charge to request the information.

Signature of Patient or Representative _____

Date _____

Patient Representative (if patient is a minor) _____

Relationship to Patient _____