AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Aspire Plastic Surgery, LLC • 7910 W. Jefferson Blvd., Suite 212 • Fort Wayne, IN 46804
Phone 260.427.7473 • Fax 260.432.3189

Patient's Name____

Date of Birth______________________ Soc. Security No.______________________

I authorize the named health care provider to release the information or records specified below to Aspire Plastic Surgery, LLC via secured electronic transfer or fax.

❑ Summit Plastic Surgery, PC

❑ Other____

Records authorized to be released:

❑ Entire Medical Records to Date

❑ Specific portions of the Medical Record______________________________

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This authorization will expire one year from the date indicated below.

I understand that I can revoke this authorization at any time by written request to the health care provider but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I understand that the material released as a result of this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations and laws applying to medical information release.

I understand that I am not required to sign this authorization to ensure health care treatment, payment, or enrollment in my healthcare plan, or eligibility for benefits.

______________________________ ______________________
Signature of Patient or Representative Date

______________________________ ______________________
Relationship to Patient Date