AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Donen Davis Plastic Surgery, LLC to obtain any and all medical records concerning my care from any physicians, hospital or other health care professional that has provided medical care to me in the past.

I also authorize Donen Davis Plastic Surgery, LLC to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize Donen Davis Plastic Surgery, LLC to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third party administrator or managed care company and for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

_____ _____

Patient Signature Date

_____

Printed Name

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Health Insurance Portability & Accountability Act of 1996 (HIPPA), in order for your physician or staff of Donen Davis Plastic Surgery, LLC to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

Please choose one:

☐ I **DO NOT** authorize Donen Davis Plastic Surgery, LLC to release any or all information
Initials concerning my medical care to any individual.

☐ I **DO** authorize Donen Davis Plastic Surgery, LLC to release any or all information concerning
Initials my medical care to the below listed individual(s).

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Patient Signature Date

_____

Witness