AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____

Print Patient's Name

Hereby authorize any and all physicians or entities involved in my medical care to disclose my health information to:

Menard Plastic Surgery, PC
401 Towncenter Boulevard
Suite B
Tuscaloosa, Al 35406
Telephone: 205-391-9038
Fax: 205-391-4688

Information to be released: **Entire Medical Record**
Date of Services: **Entire time under care of Physician**
Purpose of Information: **Continuity of Care**

This authorization may be revoked at any time by providing a written notice of revocation to the manager at Menard Plastic Surgery, PC except to the extent that the provider above has already taken action in reliance on it. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rules. This authorization will terminate in one year.

_____ _____

Patient or Guardian Signature **Date**