Plastic Surgery Center

MEDICAL AUTHORIZATION FOR PATIENT INFORMATION

I, ______________________________ HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, MEDICAL PRACTITIONER, CLINIC, OTHER MEDICAL OR MEDICALLY RELATED FACILITY, PHARMACY, INSURANCE COMPANY OR GOVERNMENT AGENCY TO DISCLOSE OR FURNISH TO DR. HASS, OR THEIR REPRESENTATIVES, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY, MEDICAL HISTORY, DENTAL HISTORY, CONSULTATIONS, PRESCRIPTIONS, TREATMENT OR BENEFITS AND COPIES OF ALL APPLICABLE RECORDS THAT MAY BE REQUESTED. I ALSO AUTHORIZE DR. HASS TO RELEASE MEDICAL INFORMATION TO MY INSURANCE COMPANY, PHYSICIANS, HOSPITALS OR OTHER MEDICAL PROFESSIONALS AS WARRENTED FOR MY TREATMENT.

I ALSO REQUEST THAT ____,
FAMILY MEMBER / DOCTOR

RELATIONSHIP, ______________________________, BE ALLOWED MEDICAL INFORMATION

ABOUT MY CONDITION.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

SIGNED: ______________________________ DATE: ______________________________
PATIENT'S SIGNATURE

PATIENT'S NAME: ______________________________
PLEASE PRINT

PATIENT'S DATE OF BIRTH: ______________________________

SOCIAL SECURITY NUMBER OF PATIENT: ______________________