Jesse E. Smith MD, FACS

Facial Plastics and Reconstruction

Release of Information Request

Patient's Name_____ **Maiden/Former Name:**_____

Patient'sAddress:_____

City, State, Zip:_____

Birth Date:_____ **Social Security#:**_____-_____-_____

Home Phone:_____ **Other Phone**:_____

I, Authorize: _____

To Release to: _____

The following information may be released:

- ○ Entire Medical Record
- ○ Specific Records From _____ to _____
- ○ Immunizations
- ○ Billing Record
- ○ ⁞Only: _____

Purpose if Disclosure:

- ○ Medical Care
- ○ Insurance
- ○ Attorney
- ○ Other: _____

I consent to the release of the indicated sensitive, legally protected records **(patient to initial).**
Mental Health Records……._____
HIV or AIDS …….._____
Chemical Dependency……._____
Genetic Testing……._____

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.

I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____
Signature of Patient or Representative: Date:

_____
Printed Name: Relationship to Patient:

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FR Part2) and cannot be disclosed without this written consent unless otherwise protected.