BODY GARAGE PLASTIC SURGERY & MEDICAL SPA
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AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____

I REQUEST AND AUTHORIZE TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO:

NAME: _____

ADDRESS: _____

CITY: _____

PHONE: _____

FAX: _____

THIS REQUEST AND AUTHORIZATION APPLIES TO:

- ☐ ALL RECORDS
- ☐ HISTORY AND PHYSICAL
- ☐ LABRATORY REPORTS
- ☐ X-RAYS
- ☐ PATHOLOGY REPORTS
- ☐ DISCHARGE SUMMARY
- ☐ X-RAY REPORTS
- ☐ OPERATIVE REPORTS
- ☐ DOCTOR/CLINIC NOTES
- OTHER: _____

THE ABOVE MENTIONED PROTECTED HEALTH INFORMATION MAY BE SUBJECTED TO RE-DISCLOSURE BY THE PARTY RECEIVING THE INFORMATION AND MAY NO LONGER BE PROTECTED BY THE PRIVACY RULES.
BY SIGNING THIS FORM, YOU AUTHORIZE THE PRACTIVE TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU FOR THE REASONS MENTIONED ABOVE. YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, SIGNED BY YOU. HOWEVER, SUCH A REVOCATION SHALL NOT AFFECT ANY DISCLOSURES WE HAVE ALREADY MADE IN RELIANCE ON YOUR PRIOR AUTHORIZATION.

PATIENT SIGNATURE: _____

DATE: _____