Medical Information Release Form

Name:_______________________________________ DOB:_____/_____/_____

Release of Information

- ○ I hereby authorize Yarrow Bay Plastic Surgery and its employees and agents, to release my personal health information (e.g. information relating to the diagnosis, treatment, payments and health care services provided or to be provided to me). This information may be released to:
  - ○ Spouse: ____
  - ○ Child(ren): ____
  - ○ Other: ____

    ____
- ○ Information is not to be released to anyone.

* This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: O my home O my work O my cell

If unable to reach me:

- ○ You may leave a detailed message
- ○ Please leave a message asking me to return call
- ○ Other: ____

Patient Signature: ______________________________________ Date: ____/_____/_____