Pollack Plastic Surgery

Complete and email this form to **records@drpollack.com**

## Request /Authorization for Health Information (Medical Records)

| **Patient Information** | |
|---|---|
| *Patient Name: | Also known as: |
| *Date Of Birth: / / | *Telephone: ( ) - |

***Release Records to:** *Where do you want records sent? Who do you want to receive records?*

◯ MYSELF Email:

◯ OTHER (Complete section below)

Name Phone:

Street Address City State Zip

FAX:

***Health Information to be Released:** *What do you want sent or released?*

Routine Record Sets **- For Dates of Service**: **FROM:** **TO:**

☐ Clinic Visit (office notes, procedure notes, operative notes)

☐ Other Records (*Please Specify)* :

***Purpose/ Use of the Information:**

◯ Continued Care ◯ Legal ◯ Personal ◯ Other:

**Name/Signature of Patient or Authorized Representative**

*Printed Name: *Date/Time:

*Signature:

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