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Diplomate, American Board of Facial Plastic and Reconstructive Surgery

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I, _____, authorize _____
to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons:

1. _____ 3. _____
2. _____ 4. _____

YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

Please list phone numbers where you would like us to contact you for:

- ◆ Reminder notices
- ◆ Changes on scheduled appointments
- ◆ Messages for the above can be left on an answering machine— Yes, No

1. _____ 2. _____
3. _____ 4. _____

Patient name, (Please Print): _____

D/O/B: _____ S/S#: _____

Patient Signature or Legal Guardian