MICHAEL C. EDWARDS, MD, FACS
PLASTIC SURGERY
Experienced, compassionate care for beautiful results

REQUEST AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This form will not be used for authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

PATIENT DATA

Full Name (Last, First, Middle)	Date of Birth (MM/DD/YYYY)	Patient SSN

Period of treatment (MM/DD/YYYY – MM/DD/YYYY)

Type of Treatment: ☐ Outpatient ☐ Inpatient ☐ Both

RELEASE

I authorize ______________________________ to release my patient information to:

MICHAEL C. EDWARDS, MD, FACS
653 N TOWN CENTER DRIVE, SUITE 214
LAS VEGAS NV 89144
(702) 248-8989
Fax: (702) 243-7923

Reason for Request/Use of Medical Information:
- ☐ Personal Use
- ☐ Insurance
- ☐ Continued Medical Care
- ☐ School
- ☐ Legal
- ☐ Other (please specify)

Information to be Released:

- ☐ Medical records pertinent to surgery on or around______________
- ☐ Any photographs
- ☐ Radiographic studies
- ☐ Lab or pathology results

Authorization Start Date:

Authorization Expiration:
- ☐ Date ______________________
- ☐ Action Completed: ______________________

RELEASE AUTHORIZATION

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.

d. Dr. Michael C. Edwards may not condition treatment, payment, or eligibility for benefits on failure to obtain this authorization.

I request and authorize the named provider to release the information described above to the named individual/organization indicated.

Signature of Patient/Parent/Legal Patient Representative	Relationship to Patient (if applicable)	Date
X		X / /

For Staff Use Only-(To Be Completed only Upon Receipt of Written Revocation)

☐ AUTHORIZATION REVOKED Revocation completed by ________________Date ___/___/___