

## Authorization for Request for Health Care Information

I hereby request and authorize \_\_\_\_\_  
Name or person or organization to release records

\_\_\_\_\_  
Address/City/State/Zip Code

To release copies of my medical records to **Dr. Gregory P. Pisarski of Gulf Coast Plastic Surgery** located at **215 Oak Drive South, Ste J** in **Lake Jackson, TX 77566**.

This authorization applies to all of the reports checked:

- |  |  |
|--|--|
| <input type="checkbox"/> History                 | <input type="checkbox"/> Physical Examination              |
| <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> Blood Tests                       |
| <input type="checkbox"/> Operative Notes         | <input type="checkbox"/> Laboratory Tests                  |
| <input type="checkbox"/> Pathology Report        | <input type="checkbox"/> Patient Information Questionnaire |
| <input type="checkbox"/> Pre/Post Op Photographs | <input type="checkbox"/> Health Assessment Questionnaire   |

### Purpose of disclosure: (check all that apply)

- |                                       |                                      |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Attorney    |
| <input type="checkbox"/> Insurance    | <input type="checkbox"/> Other _____ |

### Prohibition of Redisclosure

Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written authorization of the person to whom it pertains.

This authorization is valid for up to one year from the date of signature by the participant.

\_\_\_\_\_  
Signature of Patient  
*The patient may revoke this authorization in writing at any time*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Identification Number

\_\_\_\_\_  
Signature of Witness (optional)

\_\_\_\_\_  
Date