



# GULF COAST PLASTIC SURGERY *Gregory P. Pisarski, MD*

504 This Way, Suite C • Lake Jackson, TX 77566 • (979)297-9289 • FAX(979)299-1007  
10905 Memorial Hermann Dr, Suite 207 • Pearland, TX 77584 • (281)598-6808

## Authorization for Release of Health Care Information

I hereby request and authorize **Dr. Gregory P. Pisarski of Gulf Coast Plastic Surgery** to release copies of my medical records to:

\_\_\_\_\_  
Name or person or organization to receive records

\_\_\_\_\_  
Address/City/State/Zip or Phone/Fax number

This authorization applies to all of the reports checked:

- |  |  |
|--|--|
| <input type="checkbox"/> History                 | <input type="checkbox"/> MRI/Mammogram/Ultrasound report   |
| <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> Blood Tests                       |
| <input type="checkbox"/> Operative Notes         | <input type="checkbox"/> Laboratory /Pathology 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   |
| <input type="checkbox"/> Physical Examination    | <input type="checkbox"/> Other _____                       |

### 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

\_\_\_\_\_  
Date of Birth / Social Security #

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

\_\_\_\_\_  
Date