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 Request of Health Care Information

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

____
Address/City/State/Zip or Phone/Fax number

To release copies of my medical records to ***Dr. Gregory P. Pisarski of Gulf Coast Plastic Surgery*** located at ***504 This Way, Ste C*** in ***Lake Jackson, TX 77566.***

This authorization applies to all of the reports checked:

__ History
__ Progress Notes
__ Operative Notes
__ Pathology Report
__ Pre/Post Op Photographs
__ Physical Examination
__ MRI/Mammogram/Ultrasound report
__ Blood Tests
__ Laboratory /Pathology Tests
__ Patient Information Questionnaire
__ Health Assessment Questionnaire
__ Other ______________________

Purpose of disclosure: (check all that apply)

__ Medical Care
__ Insurance
__ Attorney
__ 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