GULF COAST PLASTIC SURGERY Gregory P. Pisarski, MD

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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:

__ 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 — Date

The patient may revoke this authorization in writing at any time

____ ______________________________

Patient's Printed Name — Date of Birth / Social Security #

____ ______________________________

Signature of Witness *(optional)* — Date