# RECORDS RELEASE AUTHORIZATION

**BEACHWOOD PLASTIC SURGERY & MEDICAL SPA**
3609 Park East Drive, Suite 206
Beachwood, OH 44122
Fax: 216-514-8877  Phone: 216-514-8899

Patient's name: _____

Date of birth: ____/____/____

Social Security Number: _____-___-_____

Address: _____

_____

_____

Telephone number: (____) _____-_____

Please release my medical records **from**:

Name of provider: _____

Provider's address: _____

_____

_____

And send them **to**:

Name of provider _____

Provider's address: _____

_____

_____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ Date: _____

Patient's Signature