GREGORY MACKAY, MD
EUGENIA PAGE, MD

SILK

PLASTIC SURGERY
& WELLNESS

Authorization for Release of Medical Records

Date of Request: _____

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Phone Number: _____

☐ Fax ☐ Mail ☐ Pickup

Purpose or need for information: _____

- ☐ All Records
- ☐ Labs/Pathology Reports
- ☐ Progress Notes
- ☐ Billing Statements
- ☐ Implant Information (including operative report)
- ☐ Other _____

I hereby authorize Silk Plastic Surgery, LLC

RELEASE/OBTAIN
(circle one)
The protected health information regarding the above-named person to/from:

Person/Institution: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I acknowledge that providing my authorization is voluntary and that I can revoke it in writing at any time, except for any disclosures made before the revocation. I also understand that I can review and obtain copies of the information to be shared.

I am aware that the health records and information disclosed may be protected under the Federal Health Insurance Portability and Accountability Act (HIPAA). I recognize that this information could potentially be re-disclosed by the recipient, at which point it may no longer be protected by HIPAA. Additionally, I understand that my records might be protected by state law, and they cannot be disclosed without my written consent unless permitted by law and/or regulations.

The release of the following information may be subject to additional laws. I agree that this information will only be disclosed if I initial next to the relevant type of information:

HIV/AIDS ____ Mental health information ____ Genetic testing information ____ Drug/alcohol, treatment, or referral info. ____

This Authorization for the Release of Protected Health Information will remain valid for one (1) year from the date below. By signing, I confirm that I have read and understood the contents and authorize the release of the information.

Signed: _____ **Witness:** _____
(Patient/Legal Guardian)