PARK MEADOWS COSMETIC SURGERY

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____ Date of Birth:_____

Address_____

_____

Phone_____ Email_____

I hereby authorize and request medical information **from**:

Park Meadows Cosmetic Surgery, PLLC
Park Meadows Outpatient Surgery, LLC
7430 E Park Meadows Drive, Suite 300
Lone Tree, CO 80124

info@pmcsdenver.com
303-706-1100
www.ParkMeadowsCosmeticSurgery.com

Covering the period from _____ to _____

Information Requested:

_____consultation/progress notes _____photos _____billing/insurance
_____operative reports _____pathology reports _____other:_____

Purpose of requested use or disclosure:

_____insurance _____continuing care _____patient request
_____leaving the practice _____legal _____other:_____

Release **To****:

Name / Facility:_____

Address_____

_____

Phone_____ Fax_____

_____Check here if acceptable to send records via Klara (HIPAA compliant text messaging)

_____Check here for records to be printed and mailed (applicable postage fees apply)

Expiration: This authorization shall expire upon (check one):

_____Fulfillment of this request* _____Expiration of 1 year from the date of this authorization, unless sooner revoked by me

- I understand this authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance upon it.
- I understand the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that the health care provider identified above may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing this authorization.

_____

Printed Name of Patient or Authorized Representative (A copy shall be considered as original) Date

****Please note that this process can take up to 30 days.**