CONSENT TO OBTAIN / RELEASE OF INFORMATION

SHELL COSMETIC SURGERY CENTER
1068 CRESTHAVEN RD SUITE 200
MEMPHIS, TN 38119

PLEASE PRINT NEATLY (EXCEPT SIGNATURE) AND PROVIDE COMPLETE INFORMATION IN EACH SECTION

PATIENTS'S LEGAL NAME: _____ **BIRTH DATE**: _____

By signing this form, I am allowing Shell Cosmetic Surgery Center to ___ OBTAIN ____ RELEASE medical information concerning the above named patient to or from the person or facility listed below:

_____
Name of Person and/or facility who will send or receive information

_____
Complete mailing address Phone/Fax#

CHECK THE INFORMATION TO BE DISCLOSED:

Dates of service requested: _____ to _____

_____ Office/Visit Notes ____ Discharge Summaries ____ Laboratory results

____ History and Physical ____ Consultation reports ____ Test Results (EKG,Imaging etc)

____ Other, please specify _____

PLEASE CHECK THE REASON FOR RELEASE BELOW; AND PROVIDE A DATE BY WHICH INFO IS NEEDED:

____ Insurance ____ 2nd opinion ____ Rehab/disability ____ Personal File

____ Moving out of the area ____ Transferring care ____Legal ____ Medical Care

- The authorization lasts for one year after the date you sign it unless you enter a different date here _____
- The authorization may be cancelled in writing at anytime. A cancellation will not change releases that happen before the cancellation.
- A photocopy/fax of this authorization will be treated the same as an original
- Shell Cosmetic Surgery Center cannot prevent redisclosure of your information by the person or organization who receives our records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Shell Cosmetic Surgery Center from any and all liability resulting from redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.
- Medical records are subject to a $20.00 copy fee after the first 10 pages.

_____ _____ _____
Patient/Legal Guardian Signature Date Authority to act on behalf of patient (attach document)