5170 E Glenn St #100
Tucson, AZ 85712
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S FULL NAME: ______________________________

ADDRESS: ______________________________

DATE OF BIRTH: ______________ **PHONE #:** ______________

RELEASE INFORMATION TO:

☐ **Patient – Self** ☐ **Pick up** ☐ **Fax** ______________

☐ **Another Office:** ______________________________

Address: ______________________ **Fax:** ______________

☐ **Our Office: Arun Rao, MD**

From: Dr. ______________________ **Phone:** ______________

Address: ______________________ **Fax:** ______________

THIS AUTHORIZATION RELEASES RAO PLASTIC SURGERY AND ANY OF THEIR STAFF, EMPLOYEES AND AGENTS OF ANY RESPONSIBILITY FOR INFORMATION CONTAINED IN SUCH RECORDS RELEASED IN CASE OF LOSS OR THEFT FROM MY PERSON, OR DISTRESS ANY TYPE CAUSED TO ME OR OTHER. RAO PLASTIC SURGERY WILL NOT BE HELD LIABLE FOR ANY MISUSE OR MISUNDERSTANDING OF THE INFORMATION CONTAINED HEREIN AS RESULT OF THIS RELEASE.

I AUTHORIZE THE RELEASE OF ALL MY MEDICAL RECORDS, INCLUDING ALL HIV AND COMMUNICABLE DISEASE RELATED INFORMATION.

______________________________ ______________
(PATIENT SIGNATURE) (DATE SIGNED)

______________________________ ______________
(WITNESS SIGNATURE) (DATE SIGNED)

OFFICE USE: