Authorization For Release of Health Information

Patient Name: _____

Date of Birth: _____

Patient Account Number: _____

I, _____ **(full name)** herby authorize _____ **(name of medical facility with medical records)** to release my medical records to the following medical practice:

La Belle Vie Plastic Surgery
1122 Medical Center Drive
Wilmington, NC 28401
(910) 338-5900 Main
(910) 338-5899 Fax

I fully acknowledge that this consent allows any and all records in your possession, including photos, test results, and pathology reports, to be forwarded to the above listed address. My records may also be sent by fax when requested. I understand my records will not be shared with any other medical office other than the listed medical office above without my written consent.

My signature below confirms the authorization to release my records immediately and this authorization shall expire 60 days from the date signed.

Patient Signature: _____

Printed Patient Name: _____

Date Signed: _____

If patient is under the age of 18 or unable to sign:

Patient's Advocate Signature: _____

Printed Name of Advocate: _____

Date Signed: _____