



AESTHETIC FACIAL BODY PLASTIC SURGERY  
DR. PHILIP A. YOUNG, MD DR. RIKESH T. PARIKH, MD

**AUTHORIZATION FOR RELEASE OF MEDICAL  
RECORDS/PROTECTED HEALTH INFORMATION**

This document must be signed by the patient or person authorized by law.

Name:

Address:

City:

State:

Zip Code:

Date of Birth:

Social Security Number:

Other identifying information if applicable (other names):

Transmission by facsimile or electronic means authorized to expedite transfer of records.

I, \_\_\_\_\_ hereby authorize Aesthetic Facial Body Plastic Surgery & its Doctors and Employees to release the records identified on Exhibit A to this Authorization for Release of Protected Health Information. I agree to be responsible for all photocopying charges associated with the reproduction of such records.

This Authorization for Release of Protected Health Information applies only to the release of the records identified on Exhibit A. Such records should be released to:

\_\_\_\_\_ for the following purpose(s):

I understand that providing my authorization is voluntary. I need not sign this Authorization for Release of Protected Health Information to continue to receive healthcare treatment from Aesthetic Facial Body Plastic Surgery & its Doctors and Employees. I understand that I may revoke this authorization, in writing, at any time except to the extent that disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed.

I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I further understand that my records may be protected under state law and, if so, cannot be



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disclosed without my written consent unless otherwise provided for in the law and/or regulations.

This Authorization for Release of Protected Health Information shall expire one (1) year from the date below. My signature below acknowledges that I have read, understand, and authorize the release of the information described on Exhibit A.

#### EXHIBIT A

#### DESCRIPTION OF HEALTH INFORMATION SUBJECT TO AUTHORIZATION

By placing a check-mark in the spaces below, I authorize the release of the following records pertaining to services from \_\_\_\_\_ to \_\_\_\_\_ [insert dates]:

- \_\_\_ Complete medical record (all information)
- \_\_\_ All hospital/institution records (includes nursing records/progress notes)
- \_\_\_ Transcribed hospital/institution records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)
- \_\_\_ Laboratory reports
- \_\_\_ Pathology reports
- \_\_\_ Diagnostic imaging reports
- \_\_\_ EKG/cardiac reports
- \_\_\_ Physical/occupational therapy reports
- \_\_\_ Billing statements
- \_\_\_ Physician office/clinical records
- \_\_\_ Implant information (including operative report)
- \_\_\_ Photographs

Release of the following information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my initials in the applicable space next to the type of information:

- \_\_\_ HIV/AIDS information
- \_\_\_ Mental health information
- \_\_\_ Genetic testing information
- \_\_\_ Drug/alcohol diagnosis, treatment, or referral information



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I hereby certify that I have read the foregoing and fully understand the meaning and effects thereof, and intending to be legally bound, have hereunto agreed to the above terms and conditions.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Printed Name