BASILE PLASTIC SURGERY

Consent for Release of Medical Records

I, _____, hereby authorize _____

_____

to release my full and complete medical records to and as requested by:

Andrea P Basile, M.D., 803 Vanderbilt Beach Road, Naples, FL 34108

Fax: 239-514-4444 ; Phone: 239-514-8777 ; Info@BasilePlasticSurgery.com

I understand that I have a right to withdraw this authorization at any time, except to the extent that action has been taken by my authorization. Such revocation must be in writing and sent to the Medical Director.

SIGNED:_____ DATED: _____

WITNESSED: _____

RECORDS REQUESTED:
Lab results: _____
Imaging Results: _____
Pathology Results: _____
Operative Reports: _____
Photographs: _____
Implant Information: _____

Other records/studies:
_____
_____
_____
_____

REQUEST SENT DATE: _____ (to be completed by BPS office)