Medical Records Release

Date:______________________________

Patient Signature:

____ ____________________________________

Print Patient Name:

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Date of Birth:

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** To protect your privacy in accordance with HIPAA standards, photo id must accompany your request for release of your medical records. If you are faxing this form to our office, please include a faxed copy of a photo id that also contains your signature (ie: driver's license). If you are presenting this form in person, please be prepared to present photo id which also contains your signature.**

By signing this document, you agree to the exchange of records between:

Raleigh Plastic Surgery Center & The MedSpa at Raleigh Plastic Surgery Center.