Aesthetic Enhancement
COSMETIC SURGERY & LASER CENTER

Release of Medical Records

Date _____

I _____ *(Patient or Guardian)* hereby authorize the following person/office to release and disclose information to Aesthetic Enhancement Cosmetic Surgery & Laser Center:

Company _____ E-mail _____

Contact _____

Address _____ Phone _____

City _____ State _____ Zip _____ Fax _____

Person Requesting Release of Medical Records:

Date of Birth Social Security #

Information to be Released:

Entire Medical Record	Progress Notes	Laboratory Results	Diagnostic Work
History / Physical Exam	Medication List	EKG	List of Allergies
Insurance Information	Photos	Non-Surgical Procedures	All Surgeries

Surgeries from to

Send to: **Aesthetic Enhancement Cosmetic Surgery & Laser Center**, 525 Oak Centre Dr, Suite 260, San Antonio, TX 78258
Phone 210-496-2639 Fax 210-496-2376

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the organization or individual releasing the information on behalf of the facility. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify, this authorization will expire in one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Facility Privacy Officer.

If medication information is being released directly to myself (patient), I understand that it may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Aesthetic Enhancement Cosmetic Surgery & Laser Center or my physician, staff or agents of AESCLC liable for any misinterpretation in my medical record as a result of not consulting my physician for the correct interpretation.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) and Hepatitis B Virus. It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

Patient Signature _____ Date _____

Witness Signature _____ Date _____