

Release Medical Records

I _____ (*Patient or Guardian*) hereby authorize _____ to release and disclose information to:

Robert N. Young, MD
Board Certified Plastic Surgeon
3204 Napier Park
Shavano Park, TX 78231
Telephone: 210-403-2000

Person Requesting Release of Medical Records: _____

Date of Birth _____ Social Security # _____

Information to be Released:

Entire Medical Record Photos Non-Surgical Procedures All Surgeries

I request my complete medical records be released to: Robert N. Young, MD , 3204 Napier Park, Shavano Park, TX 78231

I understand that the confidential medical information released is for the specific purpose of ensuring continuation of medical care with Dr. Robert N. Young.

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 instances when the law requires release. Unless otherwise revoked, this authorization will not expire or terminate.

I understand that I may inspect or copy the information to be released, 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 records, I can contact my medical provider.

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 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 DrYoungForever or my physician, staff or agents 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 _____

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