# 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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