ORLANDO
PLASTIC SURGERY ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM EDGAR T. SOSA, DO

Patient Name: _____ Date:_____

Date of Birth: _____Social Security #: _____

Purpose/Need for Information:

____Continuation of Care by
Plastic Surgeon Specialist

____Other _____
_____
_____

Specific Documentation Request:

____Office Notes
____Laboratory Reports
____X-Ray Reports

____Other _____
_____
_____

Information Requested TO:

_____
_____
_____
_____

Forward Documentation FROM:

Orlando Plastic Surgery Associates
4106 West Lake Mary Blvd., Suite 212
Lake Mary, FL, 32746
(P) 407-333-2525 (F) 407-333-9583

This information, including diagnosis and records of any evaluation, examination, and/or treatment was rendered

To me during the period: FROM _____TO _____.

This request is authorized to include Federal and/or State protected information under Florida Statutes 394.459(9) psychiatric information, 397.053/396.112 drug and/or alcohol abuse information, 381.609 HIV and AIDS related conditions, and/or 397.501(3) records of a minor client.

I understand this authorization will expire 90 days from the date of signature below or when accepted upon, whichever event occurs first. I hereby release to the forwarding addressee, its employees, and appointed representatives from any and all liability that may arise from the release of information as I have directed.

_____ _____
Signature of Patient or Parent/Guardian Witness

_____
Relationship to Patient