Garrison Plastic Surgery
Dr. Carla Garrison
1530 E. Bradford Parkway
Springfield, MO 65804
Phone: 417-877-0630
Fax: 417-877-0695

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____

Social Security Number:_____ **Date of Birth:**_____

I hereby authorize:

Name:_____
(Name of Physician or Facility)

Address:_____

To disclose all records obtained in the course of my evaluation and/or treatment to:

Carla Garrison, M.D.
1530 E. Bradford Parkway
Springfield, MO 65804

This authorization to release medical information is being requested of you in compliance with the general terms of the confidentiality of medical information.

By my signature below, I authorize you to discuss or release all information, including medical records, x-rays, history, and findings and prognosis pertaining to my medical condition, services rendered to me, or treatment given me.

Limitations on discussion and release, if any:

This authorization (circle one) DOES/DOES NOT apply to testing regarding HIV status.

This authorization shall remain in effect for one year or until cancelled in writing.

Signature:_____

Date:_____

<u>Witness</u>

Signature:_____

Date:_____