PARK MEADOWS COSMETIC SURGERY
7430 East Park Meadows Drive · Suite 300 · Lone Tree, Colorado 80124
t: 303.706.1100 · tf: 800.844.2496 · f: 303.790.7322

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name______________________________Date of Birth:____________________

Address____

____

I hereby authorize and request medical information **from****:

________ Jeremy Z. Williams, M.D. ________Other (specify to whom): ____________________

________Christopher G. Williams, M.D. Phone:____________________

Address: ____________________

Covering the period from ____________________ to ____________________

Information Requested: ________ photos ________ progress notes

________ operative report ________pathology report

________other (specify) ____________________

Release **To****:

________ Jeremy Z. Williams, M.D. ________Other (specify to whom): ____________________

________Christopher G. Williams, M.D. Phone:____________________

Address: ____________________

Expiration: This authorization shall expire upon (check one):

________Fulfillment of this request ________Date ________Expiration of 180 days from the date of this authorization, unless sooner revoked by me

- I understand that this authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance upon it.
- I understand the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that the health care provider identified above may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing this authorization.

____

Signature of Patient or Authorized Representative (A copy shall be considered as original) Date

____

Witness Date

**Please note that this process can take up to 30 days. 10/4/2013

Jeremy Z. Williams, M.D.

Christopher G. Williams, M.D.