TRIBECA PLASTIC SURGERY

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Authorization to Release Personal Medical Information

Patient's Legal Name:_____

Maiden name/A.K.A_____Date of Birth:_____

Street Address:_____

City/State/Zip:_____

Email Address:_____Telephone:_____

I, _____, hereby authorize ***TriBeCa Plastic Surgery*** to

release my protected health information to: _____

(***Please indicate if to yourself or a physician's office.)***

Street Address:_____

City/State/Zip:_____

Email Address:_____Telephone:_____

_____

Signature

_____

Date