1825 Old Alabama Road, Suite 201 Roswell, GA 30076
Phone: 770-393-9000
Fax: 770-393-9006

MARC E. YUNE, M.D.
Facial Plastic & Cosmetic Surgery

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: ________________ Date of Birth: ________________

Telephone Number: ________________ Social Security #: ________________

I request and authorize ______________________________ to Release healthcare information of the patient named above to:

Name: **AESTHETIC SPECIALITY CENTRE/DR. MARC E YUNE**

Address: **1825 Old Alabama Road Suite 201**

City: **Roswell** State: **GA** Zip Code: **30076**

This request and authorization applies to: SCHEDULED PROCEDURES - SURGERY - OTHER

☐ Healthcare information relating to the following treatment, condition, or dates: ________________

____

☐ All healthcare information

☐ Other: ______________________________

DISCLAIMER: The information contained in this medical records consent form is legally privileged and confidential information. It is for the use of the physician or facility named above. If reader of this form is not the intended recipient for delivery, you are hereby notified that any dissemination, distribution or copy of this facsimile is strictly prohibited. If you have received this facsimile in error, please contact our office by telephone at 770-393-9000 and shred the original facsimile you have received.

☐ Yes ☐ No I have read and understand this consent for release of my medical records and have voluntarily and knowingly authorize this consent.
As CAREGIVER of the above named patient I give specific written permission to release necessary medical records to AESTHETIC SPECIALTY CENTRE.

☐ Yes ☐ No I authorize the release of any records regarding medical treatment to AESTHETIC SPECIALTY CENTRE to be issued via FAX, TELEPHONE or EMAILED

Patient Signature: ______________________ Date Signed: ________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

THIS MEDICAL RECORDS REQUEST WAS HANDLED BY: ______________________