Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

Complete Records including care plan, pathology reports, hospital reports, history and physical, lab reports, treatment record, medication record, progress notes, radiology reports and operative reports.

From: Northwest Arkansas Center for Plastic Surgery at 137 W. Van Asche Dr
Fayetteville, AR 72703, Phone: (479) 571-3100, Fax (479) 571-3101

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

To: Kelamis Plastic Surgery, Dr. Joseph Alexander Kelamis, at 1792 E. Joyce Blvd Suite 1A
Fayetteville, AR 72703, Phone: (479) 935-3227, Fax: (833) 927-2540

The purpose for this release of information is as follows: Dr. Kelamis opened a new practice.

_____
Patient Printed Name

_____
Patient Signature

_____
Date