Center for Plastic Surgery

Philip R. Humber, M.D., F.A.C.S.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please read carefully. All sections of this authorization must be filled out completely before we are permitted to disclose your protected health information. Failure to provide all information requested may invalidate this Authorization. Please print legibly in black or blue ink.

EXPLANTION: This form authorizes the use and/or disclosure of your protected health information in the manner described below and is voluntary.

Patient Name:_____ Date of Birth:_____

Please include any name changes:_____

Parent (If Minor Patient) _____ Telephone: (_____) _____

I AUTHORIZE:
The office of Philip R. Humber M.D, F.A.C.S
351 Santa Fe. Dr., Suite 220
Encinitas, CA 92024
Phone: (760) 753-1288

TO RELEASE TO:

Name:_____

Street Address:_____

City, State, Zip Code:_____

E-Mail Address:_____

INFORMATION TO BE RELEASED: (please check all that apply)

____History and Physical	____Consultation	_____Medication List
____Progress Notes	____X-Ray Reports	_____Labs
____Photos	____ Operative Reports	_____**Everything**
____Other (specify):_____		

Signature:_____(patient, parent, guardian, or legal representative)

Printed Name: _____**Date:** _____

_____

Office Use: Date Sent:_____ **By:** _____