



# Plastic Surgery & Dermatology Associates (PSDA)

## DR. LOWE'S -AUTHORIZATION FOR RELEASE OF RECORDS

### OBTAIN FROM:

### SEND OR FAX TO:

\_\_\_\_\_  
Physician/Institution

\_\_\_\_\_  
Physician/Institution

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone Fax

\_\_\_\_\_  
Phone Fax

I give my authorization for these records to be released. This request is a free and voluntary act by me.

\_\_\_\_\_  
(Signature of patient or legal representative)

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
(Printed name of patient or legal representative)

\_\_\_\_\_  
(Date)

### Specific Information Requested

\_\_\_\_\_ History & Physical

\_\_\_\_\_ Lab Reports

\_\_\_\_\_ Progress Notes

\_\_\_\_\_ X-ray Reports

\_\_\_\_\_ Operative Report

\_\_\_\_\_ Pathology Reports

\_\_\_\_\_ Other (please specify) \_\_\_\_\_