Statesboro
Plastic Surgery

Authorization to Discuss Medical Information

I, _____ do hereby authorize Statesboro Plastic Surgery physician(s) and staff permission to disclose the following information with the individual(s) listed below.

☐Appointment Date / Times ☐Diagnosis ☐X-Ray results ☐Medications

☐Any and all medical records information

Name: _____ DOB: _____

Relationship: _____

Address: _____

Phone #: _____

Name: _____ DOB: _____

Relationship: _____

Address: _____

Phone #: _____

_____ _____

Patient Name (Please Print) Date

_____ _____

Signature of Patient Date

1402 Brampton Ave * Statesboro, Georgia 30458 * phone 912-681-3330 * fax 912-681-3303