RECORDS RELEASE

Per HIPAA regulations, only physicians or persons listed below can receive your medical records from Bajaj Plastic Surgery. Please list any physician or person you want to be kept updated or informed regarding your care and treatment. **PLEASE FILL OUT ALL INFORMATION FOR THE PHYSICIAN OR PERSON LISTED ON THIS FORM.**

REFERRING DOCTOR: _____

PHONE: _____

ADDRESS: _____
Street Suite

_____
City State Zip

PRIMARY PHYSICIAN: _____

PHONE: _____

ADDRESS: _____
Street Suite

_____
City State Zip

ONCOLOGIST: _____

PHONE: _____

ADDRESS: _____
Street Suite

_____
City State Zip

OTHER DOCTOR OR PERSON: _____

PHONE: _____

ADDRESS: _____
Street Suite

_____
City State Zip

OTHER DOCTOR OR PERSON: _____

PHONE: _____

ADDRESS: _____
Street Suite

_____
City State Zip

I authorize my records to be sent to the above physicians or persons listed.

_____ _____
Signature/Print Name Date