PITTMAN PLASTIC SURGERY
BLUE SPIRAL MED SPA
AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

3320 Old Jefferson Road, Building 100
Athens, Georgia 30607
P 706-549-3203
F 706-353-3777

Date: _____

Patient Name: _____ Date of Birth: _____

I hereby authorize _____ to release my medical records to: _____

_____

_____

_____

_____

I understand this authorization includes release of all medical records including HIV/STD, psychiatric, drug/alcohol, and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date