

Renaissance

PLASTIC SURGERY CENTER

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- Send records TO Renaissance Plastic Surgery Center
 Send records FROM Renaissance Plastic Surgery Center

This is a consent to release information concerning:

Name _____ Date of birth _____

Address _____

The undersigned, hereby authorizes Renaissance Plastic Surgery Center to disclose and/or deliver, obtain, or exchange, verbally or in writing, information to/with:

(Name of Person or Institution)

(Address)

Information checked below will be released pertaining to the evaluation and treatment, EXCEPT mental health information HIV/AIDS-related information or substance abuse information UNLESS the release of such information is specifically authorized by completion and signing of the additional consent located on the back of this form.

Specific information requested to be released:

- Operative reports
 Laboratory, Pathology, Xray reports
 H & P, Patient information sheets
 Progress Notes
 Other _____
 All info, a charge of \$.50 per page for entire record

I authorize the release of the information requested above.

Signature of Patient or Legal Guardian

Date

**Specific Authorization for Release of Information
Protected by State or Federal Law**

I specifically authorize the Renaissance Plastic Surgery Center to disclose and/or deliver, obtain or exchange, verbally or in writing, information relating to:

Patient must check the appropriate box(s).

- 1. Substance Abuse
- 2. Mental Health
- 3. HIV/AIDS-Related Information
including, but not limited to diagnosis and test results

This authorization is only for the person or institution named above.

In order for this authorization to take effect, you must sign here and at the end of this form.

Signature of Patient or Legal Guardian

Date