



MICROSURGICAL BREAST RECONSTRUCTION AND VASCULARIZED LYMPH NODE TRANSFER FOR LYMPHEDEMA

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Last 4 digits of SSN: _____ Phone: _____

I request and authorize the release of healthcare information of the patient named above to Marga F. Massey, M.D., LLC. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. In the event that written revocation of this consent is not made, this authorization will automatically expire in (6) months unless expiration date is otherwise amended. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Signature: _____ Date: _____
(Patient or legally authorized patient representative)