Jennifer E. Boll, MD
Aesthetic & Reconstructive Surgery

2034 E Southern Ave, STE Y
Tempe, AZ 85282
Phone: 480-833-5200
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MEDICAL RECORDS AUTHORIZATION

Patient Name/Address	Date of Birth:	Phone Number:

I authorize **Jennifer E. Boll MD, Aesthetic & Reconstructive Surgery:**

to RELEASE medical information

to RECEIVE medical information from (Please Circle One)

Office/Facility Name: Address:	Phone:	Fax:

Please release the following information from my medical record:

____Complete Record _____Operative Report _____Radiology Report _____Lab Report(s) _____Other

Date(s) of service: _____

The undersigned hereby authorizes the physician to provide the above named persons with a copy of any and all records, documents, reports, clinical abstracts, histories and charts, of every kind and description, relating to treatment of patient described above except as indicated below. It is understood that the copy of the records will be provided to the designated company or individual only upon payment of a reasonable charge for reproduction of the records.

The undersigned further authorizes the physicians to provide the above named persons with a copy of the following records, to the extent those records relate to the described treatment:

1. Records of treatment for drug/alcohol abuse and/or psychiatric illness: _____Yes _____No
2. Records of testing and/or treatment for AIDS related disease: ____Yes _____No

The purpose of this request is for: (please CIRCLE ALL that apply)

Further Medical Care Insurance Disability Relocation Other:_____

Legal (Name & Address of Attorney): _____

This authorization shall be considered invalid after six (6) months from the date of signing. I may revoke this authorization at any time by providing the physician written notice of revocation. However, I may not revoke the authorization retroactively for information already released.

In furtherance of this authorization, I hereby waive all provisions of law and privilege relating to the disclosures hereby authorized.

Patient/Guardian Signature: Date:

X_____