EYE & FACIAL
PLASTIC SPECIALISTS
Dr. Donald Hollsten & Dr. Jordan Hollsten

# Medical Records Request

Patient Name: _____ Date: _____

Employee Name: _____ Patient DOB: _____

Requesting Party: ▢ Physician ▢ Patient

Delivery Method:

▢ Mail:

**Street Address**

_____

_____

_____

▢ Fax:

**Fax Number**

▢ 210-616-0972

▢ _____

▢ Pick-Up: **Name of person picking up records:** _____

**NOTES**: _____

_____

_____

## Patient Authorization to Release Information

I _____ hereby authorize the disclosure of my medical records to the address / phone number / designated party listed above.

**Fees:** All fees must be paid in full prior to our office sending out any medical records.

**TOTAL DUE:** _____

Signature: _____ Date: _____

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