THOMAS C. WIENER MD
AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT LEGIBLY. RECORDS WILL BE RETURNED BY EMAIL.

1. PLEASE COMPLETE ENTIRE FORM, SCAN AND RETURN IT TO DR WIENER BY EMAIL TO THOMWIEN@GMAIL.COM

2. INCLUDE A LEGIBLE AND CLEAR SCAN OR PHOTO OF YOUR DRIVERS LICENSE

DATE:_______________ ***PATIENT FULL NAME________________________________***

IF YOUR NAME HAS CHANGED, WHAT WAS THE FULL NAME USED THE LAST TIME YOU SAW DR. WIENER:

____ ***EMAIL ADDRESS:_____________________________***

SS#______________________________ ***DATE OF BIRTH__________________________***
Full social security number required

INSTRUCTION TO PATIENT*: This is permission to release any portion (specified) of your entire medical record to the organization or individual named below. This permission may be revoked at any time, but we will not be liable for the information released prior to the revocation date. The signature below represents both your permission to release the information and that you have read and understand these instructions. This authorization will be valid for 90 days following the above date. This may contain sensitive information regarding medical conditions such as, drug, alcohol use, or HIV/AIDS information.* ***If it has been longer than 7 years since you have been seen by Dr. Wiener, those records have been destroyed.***

THIS INFORMATION IS TO BE RELEASED FOR THE FOLLOWING PURPOSE:

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THE FOLLOWING DOCUMENTATION IS REQUESTED (circle one):

_1. Breast implant information and operative report

_2. Full medical record

_3. other (state specifically what is needed):

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My signature below represents both my permission to release the above requested information and understanding of the instruction above.

PATIENT SIGNATURE ____

____________________________ ______________________________
WITNESS PRINTED NAME ***WITNESS SIGNATURE***