RELEASE OF INFORMATION

NAME OF PATIENT :____

DATE OF BIRTH :____

Please list any former names your records could be filed under: ____

ADDRESS: ____

____

____

REQUESTING RELEASE OF MEDICAL INFORMATION FROM:

____

____

____

FORWARD MEDICAL RECORDS TO: **Gene Sloan, M.D.**
8315 Cantrell Road
Suite 120
Little Rock, AR 72227

Phone: 501/224-1300
Fax: 501/224-4144
E-mail : rn3@gsloanmd.com

SPECIFIC INFORMATION REQUESTED:

__________Breast Augmentation Operative Reports with Implant Information dated: _________________

__________Operative Notes

__________All Dictated Hospital Notes

__________All Office Records Except Photos (radiology report only NOT FILMS)

__________Photos (copies are acceptable)

__________C & S final Report

__________Mammogram Report (most recent)

__________Other: ____

You are authorized to furnish to Gene Sloan, M.D. and/or Aesthetic Plastic Surgery, LLC. all records pertaining to the examination and treatment of the patient identified above. The information will be used to help formulate a plan for further treatment for this patient. A photocopy of this release of medical records shall be as effective as the original. This authorization is valid for 18 months from the date hereof. Any original photos we request will be returned to you. This authorization also gives the above named physician or practice permission to discuss the patient's medical records with Dr. Sloan as needed.

____ __________________________________

SIGNATURE OF PATIENT DATE