

Mandal Plastic Surgery Center, P.A. (R 12/18/21)

Office Medical Records Release (To Doctor) Form

561.238.0040

To: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ (patient/ legal guardian full name) hereby request the release of medical records of \_\_\_\_\_ (patient full name) to:

Mandal Plastic Surgery Center, P.A.

2401 PGA Blvd., Suite 146

Palm Beach Gardens, FL 33410

This release of patient health info is for the following purpose:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

and should include all progress notes, radiologic studies, pathology reports, blood test, operative reports, diagnostic tests and other tests, notes, videos and reports relating to the above condition(s).

Patient Full Name \_\_\_\_\_

Patient DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Social Security Number (last 4) \_\_\_\_\_

Signature of Patient/ Legal Guardian \_\_\_\_\_

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_