HEDDEN PLASTIC SURGERY

William J. Hedden M.D. • J. Stephen Gunn, M.D.

REQUEST FOR MEDICAL INFORMATION AND RECORDS

Date: _____

I hereby authorize and request: _____

_____

(Phone) (Fax)

to release a copy of the below listed medical records to:

HEDDEN PLASTIC SURGERY CENTER, P.C.
140 Village Street, Suite 100
Birmingham, Alabama 35242
PHONE: (205) 980-1744
FAX: (205) 980-1334

Patient Name: _____ Medical Record # _____

Date of Birth: _____

Dates of Service From: _____ To: _____

Medical Records Requested (check all that apply)

_____ Complete Medical Record
_____ Biopsy Report(s)
_____ Lab Report(s)
_____ Consultation Reports(s)
_____ Medical Allergies:
_____ Surgical Procedures
_____ Other

Additional Comments: _____

_____

Signature of Patient or Guardian Date

_____ _____

Signature of Witness

_____