DR. ROBERT HOUSER
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ Date: _____
Please Print

To: _____
Name of Institution Holding Records

Address: _____

City: _____ State: _____ Zip: _____

Fax #: _____ Phone #: _____

I AUTHORIZE YOU TO RELEASE RECORDS TO:

Cosmetic & Plastic Surgery of Columbus, Inc.
Robert S. Houser, D.O.
41 Commerce Park Drive
Westerville, OH 43082
ph 614.890.5565 fax 614.890.5561

Release the following portion(s) of the patient's medical record during the period of _____

_____Entire Medical Record	_____Progress Notes	Other_____
_____Operative Reports	_____X Ray Reports	_____
_____Pathology Reports	_____X Ray Films	_____

By signing this authorization, the undersigned agrees not to disclose or make copies of indicated information, unless further disclosure is expressly permitted by necessary implication inherent in the purposes of the original consent or authorization. Proposed new use of information without additional written consent of the person to whom it pertains is prohibited. The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand that if there is a charge for copies, that such charges must be paid prior to release of copies.

Signature of Patient/Responsible Party:_____

Patient's Birth date:_____

Signature of Witness:_____