



ROBINSON FACIAL
PLASTIC SURGERY

Burke Robinson M.D.

MEDICAL RECORDS RELEASE FORM

Patient's Name: _____

DOB: _____

I hereby authorize the office of **Burke P. Robinson, MD, F.A.C.S.** to release my medical information to the following:

Patient/ Guardian: _____

Or to the following:

Practice/ Doctor's Name: _____

Phone: _____ Fax: _____

Address: _____

Information to be released: _____

This authorization is subject to my written cancellation at any time.

Signature of Patient/ Guardian

Date

Witness

Date