American Institute for Plastic Surgery
6020 W. Plano Parkway
Plano, Texas 75093
Alan Dulin, M.D. **Scott Harris, M.D.** **Peter Raphael, M.D.**

I, _____

give authorization for your office to release my medical records.

Please send to:

Name: _____

Address: _____

_____

Phone: _____ Fax _____

Reason for request: _____

_____

_____

Patient Signature: _____ Date: _____

Patient DOB: _____ Patient SSN: _____