Wetherington Plastic Surgery Center Release of Information
Today's Date: _________________

In order to allow Wetherington Plastic Surgery Center physicians and employees to discuss patient information with others involved in your treatment or the payment of services rendered, such as your spouse, child, relative, friend, neighbor, care taker, etc., please provide the following information:

Patient Information:

Name: ____ **D.O.B.** _______________________________

SSN: ____ **Telephone:** ___________________________

I hereby allow Wetherington Plastic Surgery Center physicians and employees to discuss/release my medical information, such as appointment reminders, to verify dates and times of appointments, pick up prescriptions, lab results, care or treatment needs, etc., with the following individuals (*if you do NOT want to list anyone's name, please write NONE on the first row):

1. **Name:** _____________________________________ **Telephone:** ____________________________

   Relationship to Patient: ____

2. **Name:** _____________________________________ **Telephone:** ____________________________

   Relationship to Patient: ____

3. **Name:** _____________________________________ **Telephone:** ____________________________

   Relationship to Patient: ____

My signature below indicates the following:
I may change the names of the individuals listed above at any time. Changes must be made in writing. This information applies to all departments at Wetherington Plastic Surgery Center of which I may be a patient.

____ ________________________

Patient's Signature **Date**

Patient's Name (Please Print): ____