John C. Pedersen, MD, FACS
270 S. Cleveland Massillon Road, Ste. C
Akron, Ohio 44333
P.330.443.0221
F: 330.303.1880

PLASTIC SURGEONS
OF AKRON

John C. Pedersen, M.D.

Patient's Name: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

I request and authorize the following entity to release health care information of the patient named above:

Name: _____

Address: _____

City, State: _____ Zip Code: _____

Phone # Fax #

To: Plastic Surgeons of Akron 270 S. Cleveland Massillon Road, Ste. C Akron OH 44333

Telephone (330) 443-0221 Fax (330) 303-1880

This request and authorization applies to:

☐ Only health care information relating to the following treatment, condition, or dates of treatment:

_____

☐ All health care information

☐ Other: _____

This information will be disclosed for the following purposes:

☐ At the patient's request

☐ _____

This authorization expires on: _____(cannot exceed six months)

I understand that I may revoke this authorization in writing at any time except to the extent that the above entity has already released information after I gave this authorization. I may revoke this authorization by writing a letter to the above entity giving the name or other specific identification of the person(s) that I no longer want to receive information. I also understand that I do not have to sign this authorization as a condition for treatment.

Once the above entity gives out the information that I want released, I know that they have no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

☐ _____ _____

Signature of patient or patient's authorized representative **Date signed**

_____

Relationship if signed by anyone other than the patient