



**AUTHORIZATION TO RELEASE INFORMATION**  
**TO FAMILY/FRIENDS (PLEASE BE SPECIFIC)**

I, \_\_\_\_\_ authorize my information to be given to:  
(Patient Name)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Regarding the **initialed** items below; I understand that by signing this form only the person(s) designated above are allowed to obtain my information and they are **only** allowed to obtain information regarding the items that I have designated below. By **initialing** beside **All Information** I understand that the person(s) listed above will have availability to all of my medical and personal information that the office of Dr. George Min/Newvue Plastic Surgery has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and/or change this authorization.

- \_\_\_\_\_ APPOINTMENT DATES/TIMES
- \_\_\_\_\_ TEST RESULTS
- \_\_\_\_\_ OFFICE NOTES
- \_\_\_\_\_ SURGERY INFORMATION
- \_\_\_\_\_ INSURANCE INFORMATION
- \_\_\_\_\_ ALL INFORMATION
- \_\_\_\_\_ OTHER \_\_\_\_\_

X \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date