



LAMBETH | Plastic Surgery
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Serving the community since 1974

William A. Lambeth, M.D.

Date: _____

I, _____, request the release of my medical records to: _____

Patient Signature _____

Print Name _____

Date of Birth _____

**** To protect your privacy in accordance with HIPAA standards, photo id must accompany your request for release of your medical records. If you are faxing this form to our office, please include a faxed copy of a photo id that also contains your signature (i.e. driver's license.) If you are presenting this form in person, please be prepared to present photo id which also contains your signature.****

If you are a guardian requesting the release of a patient's records that you have legal guardianship over, please complete the information below.

Patient Name _____

Patient Date of Birth _____

Your relationship to patient _____

Patient/Guardian Signature _____

Print Name _____

**** Photo id must accompany request****