The J. Parry Clinic
for Facial Plastic Surgery & Aesthetics

RECORDS RELEASE

PATIENT INFORMATION							
FIRST:		MI:		LAST:		PHONE #:	
ADDRESS:		ZIP:		CITY:		STATE:	

FROM: Facility / Physician Releasing Records	
Facility:	
Address:	
Phone:	
Fax:	

To: Facility / Physician Receiving Records	
The J Parry Clinic for Facial Plastic Surgery & Aesthetics	
5885 Landerbrook Drive, Suite 306 Mayfield Heights, OH 44124	
Phone:	(216) 716-7762
Fax:	(216) 716-7761

	Purpose for Release:	☐Continuation of Care ☐Relocating ☐My personal Records ☐Other: _____
	Only specific items:	☐Immunization Record ☐Consultation Report ☐Medication list ☐ Other: _____
	Only Specific Dates	From: _____ To: _____ **INCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases
	Only Specific Dates	From: _____ To: _____ **EXCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases.
	Entire Medical Record	INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases.
	Entire Medical Record	EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information relating to testing or treatment of sexually transmitted diseases
	Psychotherapy Notes:	

This applies to all information in my medical record, protected under the Code 42 Of Federal Regulations, Part 2. I need not sign this form to ensure healthcare treatment.

No HIV information can be given out with this consent form. A separate HIV Consent form can be used.

I authorize medical information to be released as indicated above. I understand this release is effective until_____, but that I may revoke my consent at any time by providing a written revocation of consent to The J. Parry Clinic for Facial Plastic Surgery & Aesthetics. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and may not be protected by federal privacy laws and regulations.

Patient Signature_____ Date: _____

Witness Signature_____ Date: _____