**American Institute for Plastic Surgery**
**6020 W. Plano Parkway**
**Plano, Texas 75093**

**Alan Dulin, M.D.** **Scott Harris, M.D.** **Peter Raphael, M.D.**

I, ______________________________________________

give authorization for your office to release my medical records.

Please send to:

Name: ______________________________

Address: ______________________________

______________________________

Phone: ______________ Fax ____________

Reason for request: ______________________________

______________________________________________

______________________________________________

Patient Signature: ______________________________ Date: ____________

Patient DOB: ______________ Patient SSN: ____________________