DR. CRAIG OSER
PLASTIC SURGERY AND MED SPA
DROSER.COM

CONSENT FOR MEDICAL RECORDS

We greatly appreciate your attention to this form.

Patient Name:_____DOB: _____

Address:_____Phone: _____

I authorize: Craig Oser, DO, FACOS, FACS

To release copies of my medical records: _____

Physician Name: Craig Oser, DO, FACOS, FACS **Specialty:** Plastic & Reconstructive Surgery
Address: 2201 Park Manor Blvd
Suite400
Pittsburgh, PA 15205

I understand that this form for information shall be in effect for 180 days following this signature. However, I understand that this authorization may be revoked at any time giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release Craig Oser, DO, FACOS, FACS from any and all liability which may arise as a result of my authorized release records.

Should my case require review by a governing agency, or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for the review.

Patient Signature :_____Date : _____

Relationship to Patient :_____Witness : _____