



Tehrani Plastic Surgery

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DISSEMINATION OF MEDICAL INFORMATION

I, _____ give permission to discuss my medical diagnosis, treatments, test results, appointments and medical information with:

1. Name: _____ Relationship: _____

Phone Number: _____

2. Name: _____ Relationship: _____

Phone Number: _____

3. Name: _____ Relationship: _____

Phone Number: _____

Please do not release any information to anyone.

Patient/Guardian Signature

Date

Patient/Guardian Printed Name

Witness Signature

Date

cc: Patient Chart