I hereby authorize the release of my medical records including operative notes, pathology reports, consultations, and pre and post-procedure pictures.

Name: _____

Address: _____

City: _____State_____Zip_____

Signature: _____Date_____

This information should be sent to:

Plastic Surgery
McElderry 8th Floor
Johns Hopkins Outpatient Center
Baltimore, MD 21287

Tel: 410-955-9471
Fax: 410-614-1296
Eml: contact@HopkinsCosmeticSurgery.com

Thank you for your cooperation and prompt attention to this matter.

Sincerely,

Division of Plastic Surgery
Johns Hopkins Hospital