BASILE PLASTIC SURGERY

Consent for Release of Medical Records

I, _____, hereby authorize Andrea Basile, M.D.

To release my requested medical records to: _____

Phone #_____ Fax #_____

Address:_____

Exceptions or Instructions:

DATED: _____

SIGNED: _____

Andrea Basile, MD 803 Vanderbilt Beach Road Naples, FL 34108 239-514-8777 fax 239-514 4444