Executive Plastic Surgery / Dr. Shaher W. Khan M.D.
43940 Woodward Ave. Suite 100 Bloomfield Hills, MI. 48302
Landmark Surgery Center
43940 Woodward Ave. Suite 200 Bloomfield Hills, MI. 48302
Phone: (734) 419-1615 Fax: (248) 934-2185

Medical Record Release & Verbal Communication Authorization

Patient Information:

- **Full Name: _____**
- **Date of Birth: _____**
- **Phone Number: _____**
- **Address: _____**
- **City, State, ZIP: _____**

Authorization to Release Medical Records & Verbal Communication

I, the undersigned, hereby authorize Executive Plastic Surgery and/or Landmark Surgery Center to release my medical records and verbally communicate with the individuals or entities listed below. I understand that these records and communication will only be shared for the purpose(s) specified and in accordance with applicable laws.

I authorize the release of my medical records and verbal communication to the following individuals/entities:

1. **Name of Recipient: _____**
   Relationship to Patient: _____
   Phone Number/Email: _____
   Fax Number: _____
   Reason for Release/Communication: _____

2. **Name of Recipient: _____**
   Relationship to Patient: _____
   Phone Number/Email: _____
   Fax Number: _____
   Reason for Release/Communication: _____

3. **Name of Recipient: _____**
   Relationship to Patient: _____
   Phone Number/Email: _____
   Fax Number: _____
   Reason for Release/Communication: _____

(*Add more recipients if necessary.*)

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Scope of Release:

- I authorize the release of the following medical records and verbal communications regarding my healthcare:

☐ Entire medical record
☐ Specific records (please specify): _____
☐ Laboratory results
☐ X-rays, MRIs, and other imaging
☐ Prescription and medication history
☐ Phone call from care team after surgery
☐ Other (please specify): _____

Expiration of Authorization:

This authorization does not have an expiration date, unless revoked earlier by me in writing.

Revocation of Authorization:

I understand that I have the right to revoke this authorization at any time by submitting a written notice to Executive Plastic Surgery and/or Landmark Surgery Center.

Signature of Patient or Authorized Representative:

- **Print Patient/Representative Name:** _____
- **Signature:** _____
- **Date:** _____

For Office Use Only:

- **Date of Release:** _____
- **Records Released To:** _____
- **Method of Delivery:** [ ] Fax [ ] Mail [ ] Email [ ] Other: _____
- **Employee Initials:** _____