

**BASSIN CENTER**  
— FOR PLASTIC SURGERY —

Dr. Roger Bassin

**Authorization for Release of Confidential Information**

I, \_\_\_\_\_ hereby authorize

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To release medical information contained in my record to:

**Roger Bassin, MD**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature or  
Legal Guardian

\_\_\_\_\_  
Patient DOB

\_\_\_\_\_  
Witness