



Premier Plastic Surgery
OF NEW ENGLAND

I hereby authorize Dr. Jagruti Patel to send all of my medical records and reports

available to: _____
(New Physician or Primary Care Physician name)

(Physician address)

(Physician address)

If you require a hard copy of your records, a \$20 charge will be collected. Thank you.

Patient Name: (please print): _____

Patient
Signature: _____

Date: _____