THE KROCHMAL CENTER
FOR PLASTIC SURGERY

Medical Records Release Form

Patient Name _____

Parent or Legal Guardian (if applicable) _____

Date of Birth _____

Name of Practice With The Records_____

Medical Record Number (if known) _____

Please transfer the following records to The Krochmal Center for Plastic Surgery:

□ Consult Notes

□ Operative/Procedure Notes

□ Progress Notes

□ Labs Including Pathology Reports

□ Pictures

□ Financial Quotes

□ My Entire Medical Chart

Transfer Methods:

Email Attachment: lookinggood@krochmalplasticsurgery.com

Fax: 312-753-3161

Address: 230 E Ogden Ave, Ste 200
Hinsdale, IL 60521

Thank You in Advance,

_____ _____
Signature Date