

# **HICKORY**

Plastic & Reconstructive  
Surgery Center

Joseph E. Fewell, MD  
Steven A. Siciliano, MD

## *Records Release Authorization*

To: \_\_\_\_\_ Re: \_\_\_\_\_  
Physician or Hospital Patient

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ S.S. Number: \_\_\_\_\_

I hereby authorize and request that you release all records concerning my illness and treatment to:

**Hickory Plastic Surgery Center  
50 13<sup>th</sup> Avenue N.E. Suite 2-B  
Hickory, North Carolina 28601  
Telephone (828) 322-8380  
FAX: (828) 328-4967**

Date: \_\_\_\_\_ Patient Signature \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Witness: \_\_\_\_\_