

**ROBERT D. KLAUSNER, M.D., FACS**  
**Facial Plastic and ENT Surgery**

26800 South Tamiami Trail, Suite 360  
Bonita Springs, Florida 34134  
www.facialdoctor.com

239-498-4YOU(4968)  
800-481-FACE(3223)  
Fax 239-498-0149

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**  
**To Dr. Klausner**

I hereby authorize the following medical records source:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ fax: \_\_\_\_\_

to furnish to **Dr. Robert Klausner** (circle one):

complete or limited to \_\_\_\_\_

with exclusion of the following: \_\_\_\_\_

\_\_\_\_\_

medical and/or surgical records

of \_\_\_\_\_ DOB \_\_\_\_\_

This includes extremely confidential medical records such as HIV/AIDS testing ,  
sexually transmissible disease, psychiatric or psychotherapeutic records, unless specific  
exclusion is noted below.

Exclusions: \_\_\_\_\_

Whatever privilege afforded by law is hereby waived.

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Initiating Staff Initials: \_\_\_\_\_  
Completing Staff Initials \_\_\_\_\_

Date \_\_\_\_\_  
Date \_\_\_\_\_