ARTISTIC PLASTIC SURGERY CENTER, PLLC
Khash A. Dehghan, MD, PhD, FACS
3515 South 15th Street, Suite 101
Tacoma, Washington 98405
Telephone: (253) 756-0933 Facsimile: (253) 759-6553
www.artisticplasticsurgery.com

RELEASE OF INFORMATION

I Hereby authorize Artistic Plastic Surgery Center, PLLC to take any required photos; and to release these photos as well as all medical information accumulated during my examinations from the date of my initial office visit until the date of the conclusion of such treatment to those individuals who, in Artistic Plastic Surgery Center, PLLC's sole determination are required to receive such information, either for the purpose of medical treatment, medical quality assurance or peer review. I also understand that these records shall be available to my insurance company if they should request them. I hereby authorize any medical facility or physicians office to release my medical records, including photos, xrays and lab reports to:

Artistic Plastic Surgery Center, PLLC
3515 South 15th, Suite 101
Tacoma, WA 98405

Signature____Date______________________________

CONSENT FOR BLOOD TESTING

This facility is governed by the laws of the state of Washington and deems to be in compliance with them.

In the event that an employee should receive a needle stick during your surgical procedure, it will be necessary that a sample of your blood be drawn and tested for HIV and Hepatitis B.

Appropriate counseling will be provided prior to obtaining a blood sample. This is done in strictest confidence and the results will not be released to anyone without your written permission. There will be no charge to you or your insurance company for this procedure.

I hereby give my consent to this procedure should it become necessary.

Patient_______________________________________

Witness_______________________________________

Date____