

Bucks County Aesthetic Center, P.C.

**William L. Scarlett, D.O., FAACS
Board Certified Plastic Surgeon**

Privacy Documentation:

I would like to be contacted in the following manner: (Please check all that apply)

Home Telephone: _____

____ Please leave a message with a call back number

____ Please leave a message with detailed information

Work Telephone: _____

____ Please leave a message with a call back number

____ Please leave a message with detailed information

Written Communication:

____ Please mail to my home address

____ Please fax to the following number: _____

____ Please email me at this address: _____

I hereby give my permission to Bucks County Aesthetic Center and associates to disclose information regarding my treatment to the following people:

Spouse: _____

Son/Daughter: _____

Parents: _____

Other: _____

Physician: _____

Address: _____

In signing this release, I authorize my medical records to be faxed or mailed upon my request.

Name: _____

Birthdate: _____

Signature: _____

Date: _____