



TAROLA PLASTIC SURGERY  
NICHOLAS A. TAROLA, MD

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**Medical Record Release**

I, \_\_\_\_\_ authorize the release of my medical records to Tarola Plastic Surgery, PLLC. Please fax all records, photographs and films to 615-624-8915. Please also forward all jpeg photographs to [info@tarolaplasticsurgery.com](mailto:info@tarolaplasticsurgery.com).

Signature \_\_\_\_\_

Date \_\_\_\_\_