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PHYSICIAN RELEASE

Patient Name _____ D.O.B. _____ Date: _____
Address _____ Phone _____
City _____ State _____ Zip Code _____

Ms. / Mr. _____

is scheduled to have a hair transplant surgery with Dr. Brett Bolton.

I, Dr. _____

Address _____

Phone Number _____

Have / had Ms. / Mr. _____ under my medical care and her/his lab work and medical records are available upon request.

I understand that this is a procedure performed under local anesthesia lasting 3 to 5 hours. The patient will receive oral Valium(Diazepam) or similar pre-operatively. Anesthesia is achieved by Xylocaine with or without Epinephrine and Marcaine. A low dose steroid (Kenalog) is also used. Postoperatively, the patient receives analgesia in the form of Tylenol (Acetaminophen) or similar and Vicodin (Hydrocodone) or similar.

From my perspective, I do not foresee any contraindication with the medicines being administered or prescribed, or medical reason keeping Ms. /Mr. _____ from having this procedure performed.

This patient is cleared for a hair transplant procedure.

Doctor's Signature

Date