VAN DAM DERMATOLOGY & LASER CENTER

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MEDICAL RECORD RELEASE

Please Print Clearly

Patient Name _____ **Date of Birth** ___/____/_____

I hereby authorize Van Dam Dermatology & Laser Center to RELEASE INFORMATION IN MY MEDICAL RECORDS TO:

Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

My medical records may include diagnosis, treatment, test and examination results.

- Date of service:_____
- Specific Reports:_____
- Purpose:_____

Processing fee $10.00 _____

I hereby authorize Van Dam Dermatology & Laser Center to OBTAIN MY MEDICAL RECORDS FROM:

Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

My medical records may include diagnosis, treatment, test and examination results.

- Date of service:_____
- Specific Reports:_____
- Purpose:_____

This authorization is being given in compliance with the general terms of the confidentiality of medical information.

_____	_____	_____
Print name of patient	Signature of patient, parent or guardian	Date