



Advanced Dermatology, PC

Center for Laser & Cosmetic Surgery

PATIENT AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

Date: _____

To: _____

(Address)

Reason for Release: _____

The complete history records including pathology reports in your possession, concerning my illness and/or treatment.

Specific Date Range: _____

Name: _____

Address: _____

Signature: _____

Guardian (if applicable): _____ Relationship: _____