

Medical Records Release to Patient or Entity Form

I hereby authorize:

South Jersey Skin Care and Laser Center to release my records and all information including the diagnosis and records of any treatment or examination rendered to me.

I understand that there is a \$10 fee for records up to 10 pages. Additional pages will be \$1.00 per page. This fee must be paid in advance.

Check one:

- All records during the period _____ through _____
- All records

Send records to:

Name: _____

Address: _____

Fax: _____

Reason for requesting records: _____

| | | |
|---------------------------|------------------------------|-------------|
| Print Patient Name | Patient Date of Birth | Date |
|---------------------------|------------------------------|-------------|

Patient /Guardian Signature

Printed Name of Guardian/Representative

Additional Notes: