South Jersey SKINCARE & Laser Center

101 Gaither Drive, Mount Laurel, NJ 08054

Augusta Professional Center,
856 S. White Horse Pike, Suite 6, Hammonton, NJ 08037

RECORDS RELEASE AUTHORIZATION

I (Patient Name), _____, Date of birth (Patient), _____ hereby request and authorize you to release all information concerning my treatment in your office to the following physician:

Doctor's Name_____

Address_____

_____

_____

Phone #_____

Fax #_____

- ○ All records during the period _____through_____
- ○ All records

Thank you for your cooperation in this matter.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Guardian, or Personal Representative Date

_____ _____
Print Name of Parent, Guardian, or Personal Representative Relationship to Patient

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