SKIN PROFESSIONALS WEST

Medical Records Release/Request Authorization

I, _____, authorize Skin Professionals West to

REQUEST AND RELEASE my medical records to and from the following health care providers and health care facilities that are involved in my care:

NAME OF PROVIDER / HEALTH CARE FACILITY: _____

These records include, but are not limited to the following:

❑ **Test Results** ❑ **Visit and Operative Notes** ❑ **Images**

❑ **Pathology Slides** ❑ **Medication lists**

Patient Name: _____ Date of Birth:_____

Address:_____

Phone Number:_____

_____

Signature of Authorization of Patient/Guardian Date

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