LASER & SKIN

Surgery Center *of*
Northern California

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PATIENT HEALTH INFORMATION RELEASE FORM

I HEREBY AUTHORIZE:

Laser and Skin Surgery Medical Group, Inc.
3835 J Street, Sacramento, CA 95816
Phone: (916)456-0400 | Fax: (916)456-0499 | Email: lasercenter@skinlasers.com

TO RELEASE TO:

Physician	**Self**
Name	**Name**
Address	**Address**
Phone	**Phone**
❒ **Fax** _____	❒ **Fax** _____
❒ **Mail** _____	❒ **Mail** _____
	❒ **Pick Up**

RECORDS AND INFORMATION OF:

PATIENT NAME: _____ **DOB:** _____

❒ All Records

❒ Specific _____ From: _____ To: _____

❒ **Visit Date** ❒ **Date Range**

❒ **Pertaining to:** _____

Duration: I understand that this authorization is effective immediately and shall be valid for one year or until the date entered here _____

Right to Revoke: I understand that I may revoke this authorization in writing at any time.

Reuse: I understand that no other use will be made of this information without prior authorization from me unless such use is specifically required or permitted by law.

Although requests are typically completed within 72 hours, please allow for up to 30 days for processing from the time of receipt.

Patient Signature _____ **Date** _____