

PATIENT HEALTH INFORMATION RELEASE FORM

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I HEREBY AUTHORIZE:

Laser and Skin Surgery Center of Northern California
3835 J Street, Sacramento, CA 95816
Ph (916)456-0400 | Fax (916)456-0499

TO RELEASE TO:

Physician

Self

Name

Name

Address

Address

PH

FAX

PH

FAX

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/permitted by law.

***Please allow 48-72 hours for processing from the time of receipt.**

Patient Signature _____ **Date** _____

Physician Signature _____ **Date** _____