

# PATIENT HEALTH INFORMATION RELEASE FORM

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## I HEREBY AUTHORIZE:

Name of Provider: \_\_\_\_\_

Name of Medical Office: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## TO RELEASE TO:

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

## RECORDS AND INFORMATION OF:

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**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.

### **MEDICAL RECORDS TO BE RELEASED:**

INCLUDING LABORATORY REPORTS, CONSULTATIONS, OPERATIVE REPORTS AND PATIENT SUMMARIES, PATHOLOGY SLIDES AND REPORTS AND OTHER HEALTH INFORMATION.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_