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

❒ Visit Date _____ ❒ Date Range From: _____ To: _____

❒ 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 _____