



Clermont Internal and Cosmetic Medicine

A Patient-Centered Holistic and Cosmetic Care Center

Edriss Estime, MD

RELEASE OF MEDICAL RECORDS

Name: _____ DOB: _____

I, _____ authorize the release of my medical records to
Clermont Internal & Cosmetic Medicine. Please include the following:

- All My health Information
- Progress Notes from: _____ to: _____
- Lab results only
- Diagnostic imaging only
- Other: _____

Name of Disclosing doctor/institution: : _____

Address: _____

Phone: _____ Fax: _____

Patient name (printed): _____ Date of birth: _____

Patient/Guardian Signature: _____