AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I AM AUTHORIZING MY MEDICAL RECORDS TO BE RELEASED FROM:

LUMINOUS
DERMATOLOGY

504 W. Pueblo, Suite 202
Santa Barbara, CA 93105
t 805-682-6455 f 805-687-1482
contact@luminousderm.com

RELEASE MY MEDICAL RECORDS TO:

_____

_____

PATIENT INFORMATION (Please print):

Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____

Please release a copy of my medical records, including:

__ Progress notes (*please specify dates or conditions*):_____

__ Operative notes

__ Laboratory results

__ Diagnostic tests

__ Other _____

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS.

Patient: _____ Date: _____