LUMINOUS
DERMATOLOGY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Luminous Dermatology is authorized to **RELEASE MY MEDICAL RECORDS TO:**

(Person to whom access is being granted or recipient of copies to be sent, including *address, phone, and FAX numbers*)

Provider Name and Address: _____

Provider Phone Number: _____ **FAX Number**: _____

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

__ Pathology/Laboratory results

__ Photos

__ Diagnostic tests

__ Other _____

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS.

Patient: _____ Date: _____

Turn around time is 10-14 business days.