PHOTODERMATOLOGY • PUVA THERAPY • PHOTOTHERAPY • LASER THERAPY

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Address: _____

I, the undersigned, authorize the release of, or request access to medical record(s) of the above named patient from the office of Elisabeth G. Richard, MD.

The information may be released to (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State and ZIP)

Signature: _____ Date: _____

Relationship to Patient: _____

Printed Name of Patient or Legally Authorized Representative:

_____

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