AUTHORIZATION FOR HEALTH RECORDS

PATIENT NAME: _____ D.O.B. _____

AUTHORIZATION EXPIRES IN ONE YEAR

The above person is or has been a patient of:

Precision Skin Institute, LLC
3501 S. University Drive #5
Davie, FL 33328
P# 954-998-0345
F# 954-998-0344

The above person authorizes the following records be **released to:**

_____ Precision Skin Institute by: Provider/Facility: _____
Phone: _____ Fax: _____

OR

The above person authorizes the following records be **released by** Precision Skin Institute and forwarded to:

_____ Provider or Facility _____
Phone: _____ Fax: _____

PLEASE CHECK RECORDS AUTHORIZED FOR RELEASE:

All Medical Records _____

Biopsy report only: Most Recent _____
All reports _____

Lab work: Most Recent _____
All reports _____

_____ _____
Signature of patient/Legal Guardian/Authorized Representative Date