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Dermatology And Cosmetic Laser Surgery

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Authorization for Release of Medical Information

I hereby authorize you to furnish to:

___Physician ___Insurance Co. ___Legal ___Hospital ___Other

Name: _____Date of Birth_____

Address: _____

Phone: _____Fax: _____

Information, access to, or photocopies of the medical records of:

Patient Name: _____Date of Birth_____

Address: _____

Phone: _____Fax: _____

The foregoing is confined to the limitations as listed below:

1. Nature of information to be released: _____

2. Specific dates of treatment: _____

3. Purpose of request: _____

It is my intent that information furnished is prohibited for any purpose other than that stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I further direct that only information prior to the date of my signature below be honored, and that a photocopy of this authorization be granted the same authority as the original.

I further release Dr. Sylvie Khorenian and the staff of the Dermatology and Cosmetic Laser Surgery from all legal responsibility and/or liability that may arise from the release of such records as specified above, and I hereby wave all rights I have to preserve their confidentiality.

_____ Signature

_____ Date