AUTHORIZATION for the RELEASE of PATIENT INFORMATION

TO: ______________________________

Name of Healthcare Provider

____

Street Address City State Zip Fax

RE: ______________________________

Patient Name Date of Birth

I authorize and request the disclosure of the following medical records to

The Beautiful Skin Institute (Fax 571-485-7733):

( ) Pathology

( ) Lab

( ) Medical summary

( ) Complete

( ) Other:

____

Signature of Patient, Parent or Guardian Name Date

171 Elden Street, Suite 3B, Herndon, Virginia 20170

t. (703) 707-6339 f. (571) 485-7733 hello@beautifulskin.institute www.beautifulskin.institute