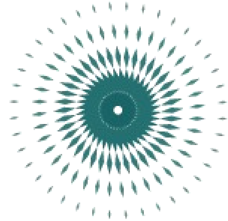

Authorization For Disclosure of Health Information

This form authorizes release of medical records from:

Physician Name: ____
Address: ____
City/State/Zip____
Phone Number____
Fax Number____

To be sent to:

M D Aesthetics and Dermatology, LLC
1021 W. Adams St. Ste LL#1
Chicago, IL 60607
P 312-579-0700 F 312-579-0701

From the records of:

____ ______________________
Name of Patient Date of Birth

Please send the following information:

Check all that apply:
_______All medical records
_______Operative Reports, applicable dates _____________
_______Lab Reports, applicable dates__________________
_______Pathology Reports, applicable dates_____________
_______Other (specify) _____________________________

The information contained herein is confidential and is being provided in response to a written authorization.

X____ X _________________________
Patient or Legal Guardian Signature Date