Abeles Dermatology
Aesthetic & Laser Arts

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby request and authorize Abeles Dermatology Aesthetic & Laser Arts to release my medical records to the person or facility listed below:

____

Name of person or organization where records are to be sent

____

Address City State Zip Code

Phone:________________________________ **Fax:**________________________________

Patient Name______________________________ **Date of Birth** ____________**Medical Record #**__________

____

Patient Address City State Zip Code

Records to be sent for the following dates of service: ______________________________

Please include the following record information:

- ☐ **Pathology report (s)**
- ☐ **Progress notes**
- ☐ **Complete health record**
- ☐ **Lab Tests**

Unless limited above, I understand that this release also pertains to medical records concerning hospitalization or treatment, including but not limited to information regarding treatment for alcohol/substance abuse, human immunodeficiency virus (HIV), or for psychiatric treatment or counseling.

It is understood that this consent is subject to revocation by me at any time except to the extent that action has been taken in reliance thereon. It is also understood that this consent expires one year from the date signed.

Signature ____ **Date**______________

Patient

Signature____ **Date**______________

Parent/Guardian Relationship

Abeles Dermatology Aesthetic & Laser Arts 221 West Grand Avenue, Montvale, NJ 07645 P201-307-0075 F201-307-5072