Bellevue Laser  Cosmetic Center

REQUEST AND CONSENT FOR RELEASE OF MEDICAL RECORDS

Date: _____

I hereby authorize **Bellevue Laser & Cosmetic Center** to release the following information from my medical record:

Patient Name: _____

Address: _____

Date of Birth: _____ SSN: _____

Information is to be released to:
Please fill out name, address, phone and fax number of medical office you want your information released to

_____

_____

_____

Information to release:
____ Dates of treatment, from _____ to _____

____ Information relating to the following treatment: _____

____ Entire medical record

Purpose of disclosure: _____

I understand this consent can be revoked at any time except to the extent that disclosure in good faith has already occurred in reliance on this consent.

Patient/Representative Signature: _____

Relationship: _____

Date: _____

Witness Signature: _____

Updated 3/2014