the skin studios
advanced aesthetics and anti-aging

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use/disclosure of my health information as described below, including records pertaining to appointment schedule, treatment, prognosis and diagnosis.

Records which may be released include: all medical, psychiatric, psychological diagnosis and treatment records, hospital records, and any records pertaining to my medical history, pathology, including tissue samples, slides and/or blocks, charts and x-ray film reports.

I understand this authorization is voluntary. I understand that all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except otherwise provided by law. I understand that a photocopy delivered in person, by mail, email or fax of this authorization is as valid as the original. I also understand that this authorization of said person authorized maybe revoked at anytime.

I furthermore authorize you to provide to and discuss with your Provider and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

Patient Name: _____ Date of Birth: _____

Person(s) authorized to receive and use this information:

_____

_____

_____ _____

Patient or Representative Signature Date