LACA DERMATOLOGY, INC.

SKIN CANCER, GENERAL DERMATOLOGY, COSMETIC

Record release authority

lacadermatology.com

Tel: 818-789-6296 | Fax: 818-789-0374

Doctor:_____

Phone:_____ Fax: _____

I, _____ am requesting that a copy of my medical

(Print Patient's name or guardian)

records, as indicated below, be sent to:

LACA Dermatology, INC.
4955 Van Nuys Blvd Ste. 516
Sherman Oaks, CA 91403
Fax: 818-789-0374

Please send a copy of the following types of medical records:

- ❑ All medical records
- ❑ Biopsy report(s)
- ❑ Pathology report(s)
- ❑ Lab report(s)
- ❑ All Chart notes
- ❑ Chart note(s) from ____/___/_____ - ____/____/____

- ❑ Other _____

_____ _____/_____/_____

(Patient Signature) (Date of Request)

_____/_____/_____

(Date of Birth)

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