LACA DERMATOLOGY, INC.

SKIN CANCER, GENERAL DERMATOLOGY, COSMETIC

Record release authority

lacadermatology.com

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

I, _____ am requesting that a copy of my medical
(Print Patient's name or guardian)
Records, as indicated below, be sent to:

Doctor:_____

Phone:_____ Fax: _____

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)