15 Executive Dr. Suite 4
Lafayette, IN 47905
P. 765-838-3428
F. 765-838-3440

Lake DERMATOLOGY, INC.

Records Release

I, _____, hereby authorize
(Patient's Name)

_____ at _____ to
(Medical Provider) address/phone/fax

release my medical records, to allow the doctor to fully examine the patient's complete

dermatological record, to _____, which include, but are not
(Medical Provider)

limited to the following, pursuant to this authorization:

☐ Complete Dermatological Record

☐ Other _____

Date of Birth: _____ Date: _____ Expiration Date: _____

Authorization of Patient/Guardian: _____

Disclaimer: The patient has the right to revoke this release at anytime if submitted in writing stating the reason for the revocation to Lake Dermatology. The provider may not withhold treatment if the patient refuses to sign this release. The patient's PHI used or disclosed may be subject to re-disclosure by the party receiving the information and may no longer be protected.