15 Executive Drive – Suite 4
Lafayette IN – 47905
P. 765-838-3428
F. 765-838-3440

Lake DERMATOLOGY, INC.

Records Release

I, _____, _____, hereby authorize to
(Name) (Date of Birth)

_____, 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 _____, at
(Medical Provider)

_____, which include, but are not limited to the
(address/phone/fax)

following, pursuant to this authorization:

- ☐ Complete Dermatological Record
- ☐ Other _____

Date: _____ Expiration Date: _____
(suggestion: one year from today)

Signed Authorization of Patient/Guardian: _____

Disclaimer: The patient has the right to revoke this release at any time 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.