

15 Executive Dr. Suite 4
Lafayette, IN 47905
(765) 838-3428
(765) 838-3440 fax



Records Release

I, _____, hereby authorize
Patients Name

_____ at _____ to
Medical Provider (First and Last name) address/phone/fax

release my medical records to Lake Dermatology Inc, which include, but are not limited to the following, pursuant to this authorization:

Complete Dermatologic Record

Other _____

Date of Birth: _____ Date: _____

Authorization of Patient/Guardian: _____