SavesTheDay Dermatology
25422 Trabuco Rd
Suite 105-333
Lake Forest, CA 92630

Medical Records Release Authorization

Patient Name: _____Date of Birth: _____

Patient Address: _____

Patient Phone #: _____

I hereby authorize Dr. Seyfzadeh to release my medical records to:

- ❑ Myself
- ❑ The following healthcare provider (Indicate name, address, fax and e-mail below)

  _____

  _____

Please select the following transmission method:

- ❑ US Mail (include check for $10 and indicate exact address below)

  _____

- ❑ Fax _____
- ❑ E-mail _____

Please select what records you want to be transmitted:

- ❑ Chart notes
- ❑ Laboratory reports
- ❑ Billing records
- ❑ Correspondence
- ❑ Consultations
- ❑ Medications

If there are specific elements of your medical records you do ***not*** wish to be transmitted, please indicate them here:

_____

_____

_____

Print Name *Signature* *Date*