KANSAS CITY DERMATOLOGY & DERMASURGERY CENTER

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RECORDS RELEASE

DATE _____

I hereby authorize Kansas City Dermatology, P.A. and/or Kansas City Laser & Dermasurgery Center, P.A. to release any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

TO: _____

_____

_____

_____

Reason: _____

Patient Name: _____ **Acct #:**_____

Address: _____

_____

_____ **Signature:**_____
(patient, parent, guardian)

_____
(Patient's Date of Birth)

This request for release of medical records expires 90 days from date of issuance.

THIS FORM MUST BE FILLED OUT COMPLETELY AND IN THE PATIENT'S HANDWRITING