



101 Gaither Drive, Mount Laurel, NJ 08054

Medical Records Release to Doctor

I (Patient Name), _____, Date of Birth (Patient) _____ hereby request and authorize you to release all information concerning my treatment at South Jersey Skin Care and Laser Center.

Check one:

- All records during the period _____ through _____
- All records

Send records to:

Name: _____

Address: _____

Fax: _____

Reason for requesting records: _____

Print Patient Name	Patient Date of Birth	Date
---------------------------	------------------------------	-------------

Patient /Guardian Signature

Printed Name of Guardian/Representative

Additional Notes:

Submit this form through fax at 856-810-9889 or provided in person at 101 Gaither Drive, Mt. Laurel, NJ 08054.