LAKES & THE SPA
DERMATOLOGY AT LAKES DERMATOLOGY

8861 W. Sahara Ave., Suite 290
Las Vegas, NV 89117
(702) 869-6667 (phone)
(702) 869-2627 (fax)

Date _____

RELEASE OF MEDICAL RECORDS

Name _____ Soc. Sec. #_____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F DOB _____

Authorization and Assignment of Medical Information

I, the undersigned, authorize the following:

_____ The release of my medical records from _____
to Lakes Dermatology/Dr. Rueckl.

_____ The release of my Lakes Dermatology medical records to _____.

_____ The release of my Lakes Dermatology medical records to myself.

_____

NOTE: If noted below, a fee of $.60 per page, plus applicable shipping or mailing fees, is due for the records.

_____ Total pages x $.60 per page = Total copy fee _____ + shipping/mailing _____

_____

PATIENT SIGNATURE _____ DATE ____/____/____
PARENT OR GUARDIAN (IF PATIENT IS UNDER 18 YEARS OF AGE)

The above/following medical information pertaining to _____ is confidential and legally privileged. Lakes Dermatology & Laser Center, Inc. has provided it as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law.

Employee Initials _____ Date_____