CENTRAL VALLEY
SKIN SPECIALISTS

Release of Medical Records

_____ _____
Patient Name Date of Birth

I hereby authorize: _____
to release my medical records to **Central Valley Skin Specialists**

Central Valley Skin Specialists
1390 West H St, Suite A
Oakdale, CA 95361
P: (209)755-7546
F: (209)444-6634

Specific request:

☐ **Full Medical Record**
☐ **Pathology Reports**

Purpose: at the request of the above-named individual. The recipient of this protected health information will not re-disclose the information, except with a written authorization or as specifically required or permitted by law. Upon request, the patient will receive a copy of this completed authorization form.

_____ _____
Patient Signature **Date**