

RECORDS RELEASE AUTHORIZATION

To: _____

(Doctor/Hospital)

Address

Phone Number

Fax Number

I Herby Authorize and Request You to Release Medical Records to:

Newport Dermatology & Laser Associates

Dore J. Gilbert, M.D.

Gregory A. Bartlow, M.D.

Melissa Gilbert, PA-C.

Michelle Aszterbaum, M.D.

1441 Avocado Avenue, Suite 806

Newport Beach, CA 92660

Tel: (949) 718-1222 **Fax:** (949) 718.1220

*Please include completed medical history records in your possession concerning
my illness and/or treatment during the period*

FROM _____ TO _____

NAME (Please Print Clearly)

DATE

ADDRESS

SIGNATURE (If relative, please state relationship)

DATE OF BIRTH