

RECORDS RELEASE AUTHORITY

To/From: _____

Address: _____

City: _____ State ____ Zip _____ Phone: _____

I hereby request my medical records be released to/from:

**Joel Schlessinger, M. D.
2802 Oak View Mall Drive
Omaha, NE 68144
402-334-7546
Fax 402-334-8627**

These records may include a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to my treatment. Inclusive dates are:

_____ To _____

Purpose of Release: _____

Date of Request

Patient Name (please print)

Patient Date of Birth

Patient Signature (or guardian)

Address

Witness

City, State, Zip and Phone

*Note: Please ensure all blanks are filled out to expedite processing

We are HIPAA compliant according to the Health Insurance Portability and Accountability Act of 1996. We strive to adhere to all regulations concerning disclosure of protected health information. For complete information, go to www.LovelySkin.com/HIPAA.