

## Records Release Authority

To/From: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Joel Schlessinger, MD**  
**2802 Oak View 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 \_\_\_\_\_ or for copies of all records check here \_\_\_\_\_

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 allow 3- 5 business days and ensure all blanks are filled in to expedite processing. Any additional requests for records made by the patient and/or insured member are subject to a \$25.00 administrative fee.

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](http://www.LovelySkin.com/HIPAA).