

 **Advanced Dermatology & Dermatologic Surgery, P.C.**

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Medical Record Release Authorization

Date ___/___/___

Patient Name: _____

Date of Birth: _____

I, _____, hereby authorize and request Dr. Hyun Soo Lee / Diana K. Sun to release complete medical record concerning all illness and treatment for the patient, _____

Patient's / Guardian's Signature: _____

Witness: _____

