

Advanced Dermatology & Dermatologic Surgery, P.C.

HYUN-SOO LEE, M.D., F.A.A.D.

DIANA K. SUN, M.D., F.A.A.D.

AHMET ALTINER, M.D

CARING CHAN, D.O

MILENA BONILLA, R-PAC.

EMMANUEL C. AGNANT, R-PAC

ADDS/Lee Skin Surgery Center, 370 Grand Ave., Suite 201, Englewood, NJ 07631 (201)886-9000; FAX (201)917-1299
ADDS/Lee Skin Surgery Center, 41-61 Kissena Blvd., Concourse Level, Suite 5A, Flushing, NY 11355 (718)886-9000; FAX (718)961-0666
ADDS/Lee Skin Surgery Center, 220 E 161st St, Bronx, NY 10451 (718)292-9197; FAX (718)292-4429

Date: ___/___/___

Medical Record Request Authorization

Patient Name: _____

Date of Birth: ___/___/___

To Doctor _____

Address: _____

Fax No. _____

I hereby authorize and request you to release to:

Advanced Dermatology & Dermatologic Surgery, P. C.
41 – 61 Kissena Blvd, Concourse Level, Suite 5A
Flushing, New York 11355
Fax No. (718) 961-0666

The complete history (records) in your possession concerning my illness and/or treatment during the period from _____ to _____ .

Patient's / Guardian's Signature: _____

(If guardian state relationship _____)

Witness: _____