REFRESH DERMATOLOGY
4914 Bissonnet Street, Suite 100, Houston, TX 77401

MEDICAL & COSMETIC RECORDS RELEASE FORM

To: _____

Address: _____

Phone: _____

Fax: _____

Patient Name: _____

Patient Date of Birth: ____ / ____ / ____ (day/month/year)

Please release the following medical and/or cosmetic records:
Check all that apply.

- ____ All medical and cosmetic records and photos (digital and print)
- ____ Progress notes
- ____ Operative notes
- ____ Pathology results
- ____ Other: _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL AND/OR COSMETIC RECORDS TO SUNEEL CHILUKURI, MD. SEND APPROVED RECORDS TO:

SUNEEL CHILUKURI, MD
4914 BISSONNET STREET, SUITE 100A
BELLAIRE, TX 77401

_____ _____
Signature of Patient/Guarantor Date

_____ _____
Printed Name of Signed Patient/Guarantor Witness