Ladera Park
DERMATOLOGY, P.A.

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Patient Name: _____

Date of Birth: _____

Last Four of SSN: _____

I _____ authorize Ladera Park Dermatology, P.A. to discuss my medical records with _____.

Relationship to patient _____.

This permission will remain in effect unless revoked by me in writing.

_____

Signature of Patient

_____

Date

_____

Witness