

lavé md
LASER AND VEIN ESTHETICS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH
INFORMATION (PHI)

PLEASE FILL OUT ALL OF THE REQUIRED INFORMATION:

PRINT NAME: _____

D.O.B: ___/___/_____

PHONE NUMBER: (____)-____-_____

I, _____ authorize the office of Dr. David Vanderpool
to release all of my medical records to

RECORDS REQUESTED:

OFFICE NOTES

ENDOSCOPY REPORTS

OPERATIVE NOTES

LAB RESULTS

PATHOLOGY REPORTS

OTHER: PLEASE DESCRIBE

ULTRASOUND REPORTS

DATE FAXED or SENT ___/___/_____

Signature of Patient