Aistheta
Medical Skin Care Center

Date:_____

I hereby request the release of my medical records or copies of such and request that they be transferred/ released from:

Doctor/ Office: _____

Address: _____

City: _____ State _____ Zip Code_____

To:

Doctor/ Office: _____

Address: _____

City: _____ State _____ Zip Code_____

for the purpose of continuum of care.

_____ ***DOB*** _____
Print Name of Patient

_____
Signature of Patient or Parent/ Guardian

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