SKIN REJUVENATION CLINIC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient:	
Address:	
Phone:	Email:
Birthdate:	Is this a Minor?

Name of Guardian or Legal Representative:	
Address:	Relationship to Patient:
Phone:	Email:

I hereby authorize Skin Rejuvenation Clinic to release all my health information.

Skin Rejuvenation Clinic	
3601 Minnesota Dr. Suite 100	
Edina, Minnesota	55435
Phone: (952) 920-6545	Fax: (952) 920-6611

The following person/organization is hereby authorized to receive my Treatment Records and Consent Forms pertaining to _____ via: ☐FAX ☐EMAIL ☐PICKUP(SELF) ☐MAIL

Person/Organization:	
Address:	
City, State:	Zip Code:
Phone:	Fax:

If filling out for a minor Print Name of Guardian or Legal Representative/Sign:

First Name: (Print)	Last Name: (Print)
Signature:	