saddleback
dermatology laser + cosmetic center

Date: _____

I hereby request: _____

_____

_____

to release any and all of my medical records to:

SADDLEBACK DERMATOLOGY & LASER CENTER

☐ **Ira Bell, M.D.**
☐ **Karen G. Benik, M.D.**
☐ **Marguerite Critelli, MD.**
☐ **Sam Truong, M.D.,**
☐ **Azin Meshkinpour, M.D., M.P.H.**
☐ **Kim Tang, M.D.**

23832 Rockfield Blvd., Suites 210 & 220
Lake Forest, CA 92630
phone: (949) 770-8115
fax: (949) 770-9191

Patient Name:_____
(please print)

Patient Signature:_____

Patient's date of birth:_____

Witness:_____

(OVER FOR REVERSE RELEASE)

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Date: _____

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