COSMETIC SURGERY & DERMATOLOGY OF ISSAQUAH
VICTOR R. MICHALAK, M.D.
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MEDICAL RECORDS RELEASE

Patient: _____ Date of Birth: _____

To: _____

_____

_____

I hereby authorize the above addressee to release the following information to:

_____

_____

_____

☐ Complete medical records
☐ All lab reports
☐ Pathology slides and reports
☐ X-Rays and x-ray reports
☐ Consultation report
☐ Surgical report

for dates of services from _____ to _____

☐ We are specifically interested in records related to the following condition: _____

_____

_____ _____
Patient Signature Date

_____ _____
Witness Date

Please include with this release HIV, STD, Alcohol and chemical dependency information, if any.

_____ _____
Patient Date

_____ _____
Witness Date