Request for Records Release

I hereby authorize the office of ____

to release the medical records in your possession to:

Karin I. Harp, MD, FAAD
32144 Agoura Road, Suite 112
Westlake Village, CA 91361

Fax: (818) 889-2747
Phone: (818) 889-2739

Patient Preference:

___ Past year (if multiple visits in one year) or past two chart notes, pathology reports, surgical op notes.

___ Complete records

___ Other: ____

Thank you,

Patient name (print) _______________________________ Date of Birth ___________________

Patient signature __________________________________ Date _________________________

APEX DERMATOLOGY – DR. KARIN I. HARP
32144 Agoura Rd, Suite 112, Westlake Village, CA 91361
TEL (818) 889-APEX FAX (818) 889-2747