



*The Center for Cosmetic
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AUTHORIZATION FORM FOR RELEASE OF MEDICAL RECORDS

I, _____ authorize J. Matthew Knight, M.D., P.A./Knight Dermatology
Institute to

- Release the records indicated below to Obtain the records indicated below from

- Complete Medical Record
 Pathology Report(s)
 Lab Report(s)
 Office Note(s)
 Surgical Procedure(s)
 Other _____

For the dates of service from _____ to _____

Patient Name

Date of Birth

Patient Signature

Today's Date