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Board Certified Dermatologist

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/INFORMATION

_____ _____
(Print Patient Name) (Patient Date of Birth)

_____ _____
(Street Address) (Social Security Number)

_____ _____
(City, State, Zip Code) (Home Phone Number)

At the request of the individual, I _____do hereby authorize
(Patient Name)
_____ to release the following:
(Name of Facility)

____History & Physical ____ Progress Notes ____ Operative Notes
____Pathology Reports ____ Laboratory Reports ____Radiology Reports
____Discharge Summary ____ Emergency Reports ____ Other

From the time period of _____ to _____.

INFORMATION RELEASE TO: _____
(Name of Company/Agency/Facility/Person)
_____
(Street Address)
_____
(City, State, Zip)
_____ _____
(Phone) (Fax)

PURPOSE OF DISCLOSURE:
____ Referral to Specialist ____ Change of Doctor ____ Insurance
____Legal Investigation ____ Disability Determination ____ Personal
____Continuing Care ____Workers Comp

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to regulations. I understand that the medical provider to whom this is authorized is furnished my not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian: _____ Date: _____