DERMATOLOGY
— & Skin Cancer —
SURGERY CENTER
an affiliate of
PREFERRED DERMATOLOGY

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB: _____ SSN: _____

**Reason for release: _____

RELEASE RECORDS FROM:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

RELEASE RECORDS TO:

Name: _____

How would you like the above party to receive your records?
(Circle one and specify below)

Fax (If under 10 pages) Mail Pick-up in Person

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Please release the following:

- ☐ Complete Medical Records
- ☐ Lab Report(s)
- ☐ Medication Allergies
- ☐ Surgical Procedures
- ☐ For the dates of service from _____ to _____
- ☐ Biopsy Report(s)
- ☐ Consultation Report(s)
- ☐ Allergy Test / Treatment
- ☐ Other: _____

**I understand that this information may include information on STDs, AIDS, HIV, mental health, and alcohol/drug abuse. I understand that the information released is for the specific purpose stated above. Any other use of this information without patient's written consent is prohibited. I understand that I have the right to revoke this authorization (in writing) at any time. The revocation will not apply to information already released in response to this authorization. **

_____ _____
Signature of patient or authorized representative Date