



*RELEASE OF MEDICAL INFORMATION AUTHORIZATION*

Date: \_\_\_\_\_

I give my consent to Dermatology Health Specialists, P.C. to receive my records from:

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone: \_\_\_\_\_

Patient name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Type of record requested:

- \_\_\_\_ Path/Lab report(s)
- \_\_\_\_ Office note(s)
- \_\_\_\_ Photo(s)
- \_\_\_\_ Entire Medical Record(s)
- \_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Guardian Date

Please check one:

- Fax to provider listed
- Mail to provider listed
- Call patient for pick-up

**Expiration Date: December 31, 2019**