DERMATOLOGY HEALTH SPECIALISTS

1693 SW Chandler Ave, Suite 250 Bend, OR 97702
16440 3rd St., La Pine, OR 97739
1245 NW 4th St. Ste. 201, Redmond, OR 97756
711 NE Irving Ave.,Bend, OR 97701
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RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Date: _____

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

Provider Name:_____

Provider Address:_____

_____

Provider Phone/fax:_____

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: One year after signed