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Full Spectrum Dermatologic Care
Cutaneous Oncologic and Cosmetic Surgery

Diplomates, American Board of Dermatology
Fellows, American Academy of Dermatology

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This form must be filled out completely

Patient ______________________________ Date of Birth __________________________
Print Name

Address ____

Day Phone __________________________ Evening Phone __________________________

Doctor or Facility Holding Records ____

____
Address City State Zip Code

Information To Be Sent To ____

____
Address City State Zip Code

This information should include:

( ) Any and all information may be released, including but not limited to mental health records, drug and/or alcohol abuse records and/or HIV test results, if any.

( ) Copies of pertinent information only, described below:

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( ) Any and all dates.

( ) Specific dates ______________________.

Signed: ____ Date: ____________________
If not signed by patient, please indicate relationship. Please furnish a copy of your Conservator/Guardian papers with this request.

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