Academic DERMATOLOGY
Cutaneous Surgery & Laser Center

Authorization for Release of Medical Information for Another Authorized Person

I hereby authorize and request Academic Dermatology, PC to release the following information to the indicated authorized person(s).

Patient Name:_____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to be used or disclosed:

- [ ] Complete Record
- [ ] Progress Notes
- [ ] Operative Notes
- [ ] Labs/Pathology
- [ ] Billing/Financial/Insurance
- [ ] Appointments

The information is being released for the following reason:

- [ ] Family Member
- [ ] Patient is a Minor
- [ ] Authorized Guardian or Caretaker

Persons to Whom Information May Be Disclosed:

Name:_____

Relationship to Patient: _____

Address: _____

City:_____ State:_____ Zip Code: _____

Phone Number: (H)_____ (C)_____ (W) _____

_____

Name of Patient (Type/Print)

_____

Signature of Patient Date