



Authorization For Disclosure of Medical Records Information

Patient Info:

Name:

First

Last

Date of Birth:

__ - __ - ____

Address:

Street Address

City

State

ZIP Code

Phone Number:

(____) ____ - ____

Medical Records From:

Facility:

Phone Number:

(____) ____ - ____

Fax Number:

(____) ____ - ____

Notes:

Medical Records To:

Facility:

Phone Number:

(____) ____ - ____

Fax Number:

(____) ____ - ____

Notes:

Release Information/Consent:

Reason: Specialist Consult Personal File Other _____

Please release the following:

Entire Record Lab/Path Results X-Ray Reports Last Visits(dates) _____ Other _____

I understand the authorization may be revoked by written notice by myself at any time. Unless otherwise stated, this authorization will be in effect for one year past the date signed below. I understand that I may inspect and copy any written correspondence released to the above party. A photocopy of this authorization shall be fully effective and as valid for all purpose as the original hereof. I understand that once my PHI has been released it may not be covered under the privacy rule of Cleaver Dermatology.

(Signature of Patient)

(Date)

(Signature of Witness)

(Date)