

North Coast Dermatology Medical Associates*

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Medical Records Release

Authorization: I authorize disclosure of medical information and health records as described below:

Name of Patient: _____ **Date of Birth** ___/___/___

Patient Phone #: _____

Record Holder: _____

Records may be released to: _____

Street Address City State Zip

I request a copy or summary of the following medical records:

- Complete Medical Record
- Biopsy Report(s)
- Lab Report(s)
- Consultation Reports
- Medication Allergies
- Allergy Test/Treatment
- Surgical Procedures
- Other _____
-

for dates of service from _____ to _____

Use of Information: The individual or entity identified above is permitted to use my information for the following purposes: **Please check all that apply.**

- Continuing Medical Care
- Second Opinion
- Personal
- Audio/Visual Marketing or Education Media
- Insurance
- Legal
- Other (please specify) _____

Patient Signature

Date

Patient Name (Please Print)

Witness

Date

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