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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, (print name) _____ (date of birth) _____

hereby authorize West Bloomfield Dermatology and Mohs Surgery

PLEASE CIRCLE ONE BELOW:

TO RELEASE RECORDS TO / TO REQUEST RECORDS FROM

Name of provider/organization/person: _____

Address: _____

Phone Number: _____

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The following information contained in my medical record (check applicable box or boxes below):

- Chart notes
- Biopsy results and/or laboratory results
- Entire patient record
- Other: _____

Purpose of requested record (check applicable box or boxes below):

- Continuation of care
- Patient or personal representative request
- Other: _____

X _____
Patient/Guardian Signature Date

X _____
Witness Signature Date