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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:____

Fax Number:____

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