WEST BLOOMFIELD
DERMATOLOGY AND MOHS SURGERY

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO SOMEONE OTHER THAN MYSELF

Date:_____

I, _____ authorize
(printed name of patient)

_____

(printed name(s) of authorized recipient(s) of medical information)

access to all information in my medical record at West Bloomfield Dermatology and Mohs Surgery. This authorizes the above named person(s) to discuss all personal health information in my file with the doctors at West Bloomfield Dermatology and Mohs Surgery and direct employees of this practice. This also authorizes this person to sign a release of records for a copy of my medical file.

X_____
(patient signature)

X_____
(witness signature)