

MEDICAL RECORDS RELEASE

PATIENT INFORMATION:

Date: _____

Patient's Name: _____ Date of Birth: _____

Phone Number: _____

Email Address: _____

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____, hereby authorize the release of my medical records to _____ from Premier Dermatology & Cosmetic Surgery, P.A to be forwarded to provider listed below.

MEDICAL PROVIDER INFORMATION:

Providers Name: _____

Address: _____

Phone Number: _____ Fax: _____

RECORDS SUBJECT TO RELEASE:

CONSENT: I acknowledge that the information provided may contain sensitive and confidential medical data. I authorize the release of this information and confirm it to be voluntary.

SIGNATURE: _____ **DATE:** _____