M | D
MODERN DERMATOLOGY
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MEDICAL RECORDS RELEASE FORM

Patient Name:

DOB:

Address:

To:

_____

physician's name

_____

physician's address

_____ _____

phone number fax number

I authorize the use or disclosure of the above individual's health information as described below:

_____ Entire Medical Records Pathology Reports Only

_____ Laboratory Results Only Pathology Slides Only

_____ Other

From this date: _____ To this date: _____

Release to: Modern Dermatology

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This authorization will expire on _____.

I understand I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand once the above information is disclosed, it may be re-disclosed by the recipient and the federal privacy laws or regulations may not protect the information.

_____ _____

signature of patient or legal representative date

_____

relationship to patient (if signed by legal representative)