

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME OF PATIENT: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ PHONE (____) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

I hereby authorize and request the following doctor or medical facility:

NAME OF DOCTOR OR MEDICAL FACILITY: _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE (____) _____ FAX (____) _____

to furnish any and all information concerning my past and present medical history and condition to Accredited Dermatology Medical Clinic Inc. Specific information requested:

- Entire medical record, including laboratory reports
- Pathology slides and reports for all biopsies and surgical procedures
- Other: _____

I hereby authorize and request the following information as the:

- Patient
- Parent of the minor patient
- Conservator of the patient
- Guardian of the minor patient

SIGNATURE _____ DATE _____