



Authorization for Release of Medical Information

Patient: _____ Date: _____

Address: _____ DOB: _____

City/State/Zip: _____ Phone: (____) _____

I authorize *Alaska Family Dermatology, LLC* to:

Send copies of my record to (or discuss information with) the provider/person/facility below

OR

Receive copies of my record from (or discuss your information with) the provider/person/facility below.

Name of Provider/Person/Facility: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Information to be disclosed:

Most recent Visit Note

Pathology Reports

Lab Reports (last 12 months)

Operative Notes

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. There may be a charge for the requested records. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to Alaska Family Dermatology, LLC.

I have read the above Authorization for Release of Medical Information and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature: _____ Date: _____

Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to patient (if other than self): _____

Printed name of Authorized Representative: _____