

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____
Telephone: _____

Records to be **released to:**

Records to be **released from:**

I do do not (check applicable box) authorize this information to be faxed.
If yes, fax number: (____) _____

Information to be disclosed (check appropriate boxes):

- Operative Report from _____
 Pathology Report from _____
 Progress Notes
 Complete Medical Records

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

You may revoke or terminate this authorization by submitting a written letter to Catskill Dermatology, PC 110 Bridgeville Road Monticello, New York 12701.

Unless otherwise indicated below, this authorization will expire ninety (90) days from the date of signature.
This authorization is effective through : _____ / _____ / _____.

Signature of Patient or Legal Representative Relationship to Patient Date