Briargate
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SUMMIT DERMATOLOGY

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Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____
Address: _____
Preferred Phone: _____

I authorize Summit Dermatology, P.C. to release the following protected health information:

- ☐ Complete Medical Record
- ☐ Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ Consultations Report(s)
- ☐ Medication Allergies
- ☐ Allergy Test Treatment
- ☐ Surgical Procedure(s)
- ☐ Other: _____

Please check one:

- ☐ For all dates of service
- ☐ For dates of service from _____ to _____

Release to:

- ☐ Patient *(Mail)*
- ☐ Patient *(Office pick up)*
- ☐ Parent/Legal Guardian *(Mail)*
- ☐ Parent/Legal Guardian *(Office pick up)*
- ☐ Release my medical information to:

Provider Name/Facility: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation
- Summit Dermatology, P.C. may charge a reasonable medical records copying fee as permissible by law.

_____ _____
Patient/Parent/Legal Guardian **Printed Name** Relationship to Patient

_____ _____
Patient/Parent/Legal Guardian **Signature** Date