MILL VALLEY DERMATOLOGY
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MEDICAL RECORDS RELEASE

To:_____

I _____hereby request that you release to:

_____
_____
_____

Use of Information: The individual identified above is permitted to use my information for the following purpose of: (please check all that apply)

[ ] Continuing Medical Care [ ] Second Opinion [ ] Other

Date Range of Health Records: From_____to_____ or ALL DATES
Indicate which records:

[ ] Consultation Reports [ ] Operative Reports [ ] Pathology Reports

[ ] Progress Notes [ ] Slides [ ] Other [ ] ALL

I hereby authorize the use of disclosure of my individual identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release of the information may no longer be protected by the federal privacy regulations. I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

Date of Request: _____

This authorization will expire on:_____

Print Patient's Name: _____

Date of Birth: _____

Signature of Patient or Legal Guardian: _____

Relationship to patient: _____

Address: _____
_____
_____