



**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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_