

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Patient's Phone#: () _____

I authorize Helendale Dermatology **to release my medical records including all laboratory and pathology reports from:**

Name of Provider/Facility: _____

Address: _____

Fax #: () _____

Signature: _____

Signature of Parent/Guardian: _____

Witness: _____