

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Patient's Phone#: () _____

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

Name of Provider/Facility: _____

Signature: _____

Signature of Parent/Guardian: _____

Witness: _____

Please forward Records to:

Helendale Dermatology & Medical Spa

Elizabeth Arthur, M.D.

Jennifer Tantalo, RPA-C

500 Helendale Rd, Suite 100

Rochester, NY 14609

FAX to : (585)266-5423

