

DERMATOLOGY, LTD.

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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

This will authorize _____ to release confidential
medical record information to:

Individual or Organization _____

Address _____

The specific information to be released is: _____

and pertains to my treatment on or about _____.

I hereby certify that I understand the nature of the release of the above information.

Patient Signature

Date

Witness

This authorization is void upon the following date or event (Maximum of 60 days
from the above date):

* This form is designed to comply with the confidentiality regulations established in the
Federal Register: Volume 40- Number 127 of July 1, 1975 and the Pennsylvania Bulletin,
Vol. 9, No. 40 of October, 1979.