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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DATE: _____

I hereby authorize Barrington Park Dermatological Associates to:

_____ Obtain medical records from:
_____ Send my medical records to:

Physician/Other: _____

Address: _____

City/State/Zip Code: _____

Phone #/Fax #: _____

Please Include: All _____ //From: _____ To: _____
DATES

_____ Chart Notes
_____ Lab Results
_____ Biopsy Reports

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

PATIENT (OR GUARDIAN IF UNDER 18) SIGNATURE

_____ **DATE:** _____