DERMWELLESLEY

Authorization for Release of Medical Information

Patient Name: _____ **DOB:**_____

Patient's Full Address: _____

I authorize DermWellesley, LLC to:

☐ **Send copies of your medical record (or discuss information with) the provider/ person/facility below.**	☐ **Receive copies of your record from (or discuss information with) the provider/ person/ facility below.**

Name of Provider/ Person/ Facility: _____

Full Address: _____

Office Phone: _____ **Office Fax:** _____

Information to be disclosed:

- ☐ **Progress Notes**
- ☐ **Pathology/ Lab Report(s)**
- ☐ **Operative Notes**
- ☐ **Cosmetic Notes**
- ☐ **Entire Medical Record**

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information including the date on this authorization unless other dates are specified. . The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to DermWellesley LLC.

I have read the above foregoing Authorization for Release of medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/ Representative Signature: _____ **Date:** _____

Printed Name of Authorized Representative: _____

Parent/ Guardian signature required for patients less than 18 years of age:

Signature of Parent/Guardian: _____ **Relationship:** _____

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