MAIN LINE DERMATOLOGY
Authorization to Release Medical Records

Patient Name: _____

Date of Birth: _____ Telephone #: _____

Specific information to be released:

_____

_____

Please state the reason for request of records:

_____

_____

I hereby authorize _____ to release my protected health information to the following entity:

Name: _____

Street: _____

City: _____ State: _____ Zip code: _____

_____ _____

Signature of Patient or Legal Guardian Date