RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Date: _____

I give my consent to Mystic Valley Dermatology Associates, P.C. to release my records to: _____

_____

_____

Patient name: _____

Date of Birth: _____

Address: _____

_____
City State Zip

Phone: _____ **E-mail:** _____

Type of record requested:

____ **Path/Lab report(s)**

____ **Office note(s)**

____ **Photo(s)**

____ **Entire Medical Record(s)**

____ **Other:** _____

_____ _____
Signature of Patient or Guardian **Date**