

311 N Sumneytown Pike, Suite 1E, North Wales, PA 19454 P 215-699-1929 F 610-871-2998

Authorization for Release of Medical Information

Patient:	Date:
Address:	DOR
City/State/Zip:	
I authorize North Wales Dermatology F	<i>LLC</i> to:
Send copies of your record to (or d	iscuss information with) the provider/person/facility below. OR
Receive copies of your record from	(or discuss your information with) the provider/person/facility below
Address.	
Phone:()	
Information to be disclosed:	
Clinic/Progress Notes	Pathology Reports
Operative Notes	Lab Reports
Cosmetic Notes	Other:
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 dated prior to and including the date on this authorization unless other dates are specified. There may be a charge for the requested records according to PA State Law. 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 North Wales Dermatology PLLC.

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:
Parent/Guardian signature required for minor (less than 18 years of age)	
Relationship to patient (if other than self):	
Printed name of Authorized Representative:	