DERMATOLOGY ASSOCIATES OF WESTERN PENNSYLVANIA

500 Cherrington Pkwy, Suite 410 Coraopolis, PA 15108
Phone: 412-262-1064
Fax: 412-262-3904

*****AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION*****

(If under 18 years of age, parent or guardian must sign)

Patient Name: _____
Date of Birth: _____/_____/_____
Address: _____
S. S. #: _____
Phone: _____-_____-_____

I hereby authorize Dermatology Associates of Western Pennsylvania to release information from my medical record to the following individual or agency. Please enter the name and address of the individual, doctor, hospital, insurance co, or other agency.

Name: _____

Address: _____

Purpose of Medical Record Release (ex. Continuation of medical treatment, payment of bill, workman's compensation, other educational, legal or insurance purposes)

_____

Date of request: _____ Date needed: _____

Release of FULL Medical Record (check one): _____ Yes _____ No

If selected "No", please indicate the time period or specific nature of information to be released:

_____

I may cancel this authorization at any time by submitting a written request to the address provided, except where a disclosure has already been made in reliance on my prior authorization. I also understand that this consent will expire either six months after the date of signature or automatically when the records request on this authorization have been mailed to the requestor.

Signature of Patient: _____ Date: _____

If the patient is unable to give consent because of physical condition or age, complete the following:

Patient is a minor _____ years of age

Patient is unable to give consent because _____

Signature of Guardian: _____ Date: _____

Printed Name of Guardian: _____

Relationship to Patient: _____

Rev 12-4-19