PLATINUM
DERMATOLOGY NETWORK™

Medical Records Release

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: (Name of Physician Practice) _____

PATIENT INFORMATION (Please print):

Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

Release the following records to _____

(Fax: _____): _____

_____

I am aware of HIPAA regulations.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient Name: _____

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Medical Records Release

Signature: _____ Date: _____