RECORDS RELEASE FORM

PATIENT NAME_____

DATE OFBIRTH_____S.S.#_____

STREET, APT#_____

CITY, STATE, ZIP CODE_____

TELEPHONE#(S)_____

DOCTOR(S)/PA SEEN AT MANHATTAN CENTER FOR DERMATOLOGY_____

1. I hereby authorize the Medical Records Department staff at Manhattan Center for Dermatology to release information from my medical record to _____Dr. _____Self (Patient) _____Email Address _____Other Party

2. Please send to:

NAME_____

ADDRESS_____

CITY, STATE, ZIP CODE_____

3. If requesting to be sent to an email address please provide address here _____

4. For the purpose of (please check one)

_____Continued Treatment

_____Legal Review

_____Insurance purpose

_____Personal review of information

_____Other (please specify)_____

5. I limit the information to be released to the following items: (Please check specific items)

_____Consultation Note

_____Operative Note

_____Pathology

_____ Entire Record (charge may be associated dependent on # of pages)

_____Other (please specify)_____

Covering records from on or about (Date)_____to (Date)_____

Signature of Patient_____

Printed Name of Patient _____ Date_____