MEDICAL RECORD RELEASE AUTHORIZATION

WESSON DERMATOLOGY
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PLEASE FILL OUT COMPLETELY & LEGIBLELY

PATIENT INFORMATION

NAME ______________________________ DATE OF BIRTH ____________________

☐ I HEREBY AUTHORIZE WESSON DERMATOLOGY TO RELEASE MY MEDICAL RECORD INFORMATION TO THE PHYSICIAN LISTED BELOW

☐ I HEREBY AUTHORIZE THE PHYSICIAN LISTED BELOW TO RELEASE MY MEDICAL INFORMATION TO WESSON DERMATOLOGY

PHYSICIAN ______________________________ PHONE ____________________

ADDRESS ______________________________ FAX ____________________

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INFORMATION TO BE RELEASED

☐ VISIT NOTE
☐ LAST FULL BODY EXAM
☐ BLOOD WORK
☐ PATHOLOGY REPORT

ADDITIONAL INSTRUCTIONS: ______________________________

I understand that my medical records can contain reports and test results that only a physician can interpret. I acknowledge that I should contact my physician regarding the entries made in my medical records to prevent misunderstanding of the information contained in these entries. I will not hold Wesson Dermatology liable for any misinterpretation of the information in my medical record as a result of not consulting my physician.

PATIENT: ______________________________ DATE: ____________________

WITNESS: ______________________________ DATE: ____________________