Precision Dermatology and Skin Surgery

Board Certified in Dermatology
Fellowship Trained in Dermatologic Surgery

Patient Information

Patient Name (Print): _____ MI: _____ DOB: _____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____

I hereby authorize Precision Dermatology and Skin Surgery, P.A. to release my medical record information to the physician, facility, or person listed below:

Name/Facility: _____ Phone: (_____) _____
Street Address: _____ Fax: (_____) _____
Apt/Unit: _____ City: _____ State: _____ Zip Code: _____

Information to be released: _____

_____

Purpose for need or disclosure: _____

_____

I understand that the information released is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any employee of Precision Dermatology and Skin Surgery, P.A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Patient Signature: _____ Date: _____

Print Name: _____ Relation (if not patient): _____