



1125 Schilling Blvd E, Ste. 105
Collierville, TN 38017
PH: 901.624.3333
Fax: 901.457.7407

Medical Records Release Form

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE LEVY DERMATOLOGY TO:
(initial below)

____ RELEASE INFORMATION TO:	____ OBTAIN INFORMATION FROM:
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Name of Provider or Facility

Address/City/State/Zip

Phone Number

Fax Number

Please initial specific information requested for release:

____ Biopsy Results and/or Lab Reports – Specify, if applicable: _____

____ Office/Surgical Notes – Specify, if applicable: _____

____ All Protected Health Information (PHI) – All Records

____ Other: _____

For the purpose of:

____ Continuing Care ____ Transferring Care ____ Other: _____

____ Personal ____ Physician

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Levy Dermatology.

I understand I may revoke this authorization at any time in writing and present my written revocation to Levy Dermatology. Unless otherwise revoked, this authorization will expire one year from the date signed below or as listed: __/__/__.

Date

Signature of Patient or Signature of Personal Representative

Description of Personal Representative’s Authority (Attach Necessary Documentation)