LEVY DERMATOLOGY

6254 Poplar Avenue
Memphis , TN 38119
PH: 901.624.3333
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# Medical Records Release Form

Patient Name: _____________________________________________ Date of Birth: ______________________

I HEREBY AUTHORIZE LEVY DERMATOLOGY TO:
(initial below)

| _____ RELEASE INFORMATION TO: | ______ OBTAIN INFORMATION FROM: |
| --- | --- |

_____________________________________________________________________________________
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)

Revised December 2020.