LEVY DERMATOLOGY

15 Old Humboldt Road
Jackson, TN 38305
PH: 901.624.3333
Fax: 731.240.1415

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.