



## Medical Records Release / Request Authorization

### Patient Information

Last Name	First Name	Middle Name
SS#	D.O.B.	Sex

### Authorization

I hereby authorize Derick Dermatology to release my medical records, which include, but are not limited to the following, pursuant to this authorization (please circle all that apply). Please note that a release of comprehensive medical records may take up to 10 business days.

- **Progress Reports Only**
- **Pathology Reports Only**
- **Comprehensive Medical Records**

I request my records from the following dates of service (please fill in the blanks below or circle "All Dates"):

**Beginning** \_\_\_\_\_ **Ending** \_\_\_\_\_ **All Dates**

Printed Patient Name

Date

Signature of Patient or Legal Representative