WASATCH DERMATOLOGY
Compassion. Tradition. Excellence.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME:_____
(Last) (First) (MI) (Maiden or Other Name)

Date of Birth ____/____/____

Address_____ City_____ State____ Zip_____

Telephone (____)_____

I hereby authorize: **Wasatch Dermatology**
5734 S 1475 E, Suite 300
South Ogden, UT 84403
Phone: 801.475.5210
Fax: 801.475.5209

to release my health information to: Dr./Clinic_____
Address _____
City _____State ____ Zip_____
Telephone (____)_____
Fax (____)_____

I specifically authorize the release of the following information (check the appropriate box or boxes below):

- ❑ Lab Reports Date From_____ To_____
  - Test(s)_____
- ❑ Pathology Results Date From_____ To_____
- ❑ Other (Specify)_____

This authorization is made for the following purpose:
- ❑ At my request, or
- ❑ Other (Specify)_____

This authorization is valid for current date of request only.

_____ ____/____/____ OR _____ ____/____/____
Signature of Patient Date Signature of Legal Guardian Date

_____
Printed Name of Legal Guardian