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: Dr./Clinic ____
Address ____
City _____________________State ____ Zip_________
Telephone (____)______________
Fax (____)______________

to release my health information to:

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

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

- ❑ Lab Reports Date From ____________ To______________
  - ○ Test(s)____________
- ❑ Pathology Reports Date From ____________ To______________
- ❑ 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