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 valid for current date of request only.

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

____
Printed Name of Legal Guardian