

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 _____

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