



Cambio Dermatology

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

I, _____
Print patient's name

SS#: _____ Date of Birth: _____

Herein authorize,

Name: _____

Address: _____

Phone: _____ Fax: _____

To release and forward a copy of my medical records to:

Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that the specific reports disclosed shall include:

Note: if your records are to include AIDS/HIV status, Mental Health Records, or Drug/Alcohol History, you must list them in the space above.

I understand that this consent is revocable upon written request to the practice, except to the extent that action by the practice has been taken in reliance on this authorization and that this authorization shall remain in force for a "reasonable" time in order to affect the purpose for which it is given.

Authorization expires: _____

PATIENT SIGNATURE

DATE

WITNESS

DATE