

## **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

| Patient Name :   | DOB :/   |
|--|--|
| Address :  |  |
| City/ State / Zip Code:  |  |
| Phone Number :()   | -  |
| REQUEST AND AUTHORIZE:   |  |
| Name:  | _ of   |
| Address :  |  |
| City/ State / Zip Code:  |  |
| Phone Number :()   | _ / Fax Number : ( )   |
| 3853<br>Hillia   | e Dermatology, LLC<br>Trueman Court<br>ard, Ohio 43026<br>1200 / Fax: 614-777-1294 |
| This request and authorization applies to: (Che                      | eck One)   |
| Health care information relating to the follo Or dates of treatment: |  |
| Most Recent Bloodwork  | Pathology Report(s) for :  |
| Other  |  |
|  |  |
| Signature of patient or patient's authorized re                      | presentative Date  |
| X  |  |