Signature Dermatology

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: ___ / ___ / ___ SS: _____ -_____ - _____

Address: _____ City/ State / Zip Code: _____

Phone Number: (____) _____ - _____

To release health care information of the patient named above to:

Name: _____ of _____

Address : _____ City/ State / Zip Code: _____

Phone Number: (____) _____ - _____ / Fax Number: (____) _____ - _____

This request and authorization applies to: (Check One)

☐ Health care information relating to the following treatment, condition,

Or dates of treatment: _____

☐ Most Recent Bloodwork ☐ Pathology Report(s) for : _____

☐ Full Record

Signature of patient or patient's authorized representative

X_____ **Date:** _____

Per the state of Ohio, the medical records fee per page: pages 1-10 $3.62 per page, pages 11-50 $0.76 per page, pages 51+ $0.30 per page.

I hereby authorize that all future payments be made via Electronic Funds Transfer to the following credit card account:

APPLICANT DETAILS	
Name	
Card Number	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Security Code	___ ___ ___ **Expiration Date:** ___ ___ / ___ ___