AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS
(Protected Health Information)

Patient Name: _____ Date of Birth: _____ Phone #: _____

PHI INFORMATION TO BE RELEASED / DISCLOSED:

❑ Any and all of my medical record (as of the date of this release.

❑ Any and all of my medical record EXCEPT for the following:

_____

❑ Specifically ONLY the following:

_____

I AUTHORIZE MY MEDICAL INFORMATION TO BE DISCLOSED TO:

Name:

Address:

City State Zip Code

PURPOSE FOR RELEASE / DISCLOSURE OF PHI:

☐ Transfer of Care ☐ At my Request ☐ Other _____

By signing this authorization, I indicate that I understand that: this release is effective for one (1) year from the date of execution; that I may revoke it at any time by providing notice in writing to the above named party, except when action has already been taken to comply with my request; and that I hereby release Kalamazoo Dermatology, P.C. from all legal responsibility or liability that may arise from the disclosure of the information set forth above relating to my records.

Patient / Parent Signature Date

Witness Date

KALAMAZOO DERMATOLOGY, P.C.

6100 Newport Road Suite 100 Portage, MI 49002-9235
Phone: (269) 343-4679 Fax: (269) 343-5929