



Dr. Lisa Renfro * Dr. Emma Lanuti * Dr. Thomas Meskey *

* Alexa Littlejohn, NP * Jim Heins, PA-C * Reid Raleigh, PA-C * Caroline Buehler, PA-C

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients name: _____ Date of Birth: _____

Previous name: _____ Social Security# _____

I request and authorize _____ to release the healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

___ Operative Notes ___ Dermatology office Notes ___ Pathology/Lab Reports

• Date(s) of Service _____

○ Other: _____

Purpose of Need for Disclosure:

___ Continued Patient Care ___ Primary Care Provider ___ Specialty Provider)

___ Personal Use ___ Insurance Claim ___ Other (_____)

I understand that the cost for processing my request will be as followed:

\$.76 per page of medical record

The actual postage cost

Preparation fee of \$22.88 when applicable

Patient/Guardian Signature: _____ Date: _____

Witnessed By/Date: _____

Date mailed or given to patient: _____

This authorization expires ninety days after it is signed.

NO MEDICAL RECORDS WILL BE FAXED