ART OF DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

Authorization for Release of Medical Information

Patient Name	
DOB	
Address	
City/State/Zip	

✸ Please fax requested information to **248-876-9144**

I authorize Art of Dermatology PLLC to:

☐ Send copies of your record to (or discuss your information with) the provider/person/facility below.

☐ Receive copies of your record from (or discuss your information with) the provider/person/facility below.

Name of Provider/Person/Facility	
Address	
City/State/Zip	
Fax Number	

Information to be disclosed:

Progress notes ☐ Operative Notes ☐ Entire Medical Record ☐
Pathology/Lab Reports ☐ Cosmetic Notes ☐

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. There may be a charge for the requested records according to MI State Law. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to Art of Dermatology PLLC.

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature: _____
Parent/Guardian Signature (Required for minor less than 18 years of age): _____
Relationship to patient (if other than self): _____
Printed name of Authorized Representative: _____

Phone number: 248-581-0333 **Fax number: 248-876-9144**