Mercy Odueyungbo, MD
Phone: 906-362-7546
Fax: 413-269-8079

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient:_____ Date of Birth:_____

Address:_____ Phone:_____

_____

I authorize the staff of Lilly Dermatology to:

___ send copies of my medical record (verbal and written) to the provider/person/facility listed below

___ receive copies of my medical record (verbal and written) from the provider/person/facility listed below

Please include:

___Operative Reports ___Pathology Results ___Lab Results ___Office Notes

___Entire Medical Record

From_____ to_____.

Provider:_____ Fax:_____

Address:_____

_____ Phone:_____

I understand that this Authorization is effective for a period of 1 year from the date of signature, unless otherwise specified. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. I understand that signing authorizes the disclosure of my protected health information as stated above.

Patient Signature:_____ Date:_____

Legal Representative:_____ Relationship to patient:_____
*If you are making this request on behalf of another individual, please include proof of authorized representative status.

Please fax to:
Lilly Dermatology
ATTN: Nursing Staff
413-269-8079

Please fax to:
Lilly Dermatology
ATTN: Nursing Staff
413-269-8079