

## AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby authorize protected health information to be released from the medical record of:

Patient's Name (Last, First): \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

**Release Records From:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

**Release Records To** (circle appropriate office):

Kahn Dermatology, PLLC	Kahn Dermatology, PLLC
5 Harrison Street	2627 Hylan Boulevard
Suite A	Building C
New York, NY 10013	Staten Island, NY 10306
Phone: 212-619-0666	Phone: 718-351-8101

I hereby authorize and request the prompt release of all medical records without exception, including but not limited to: clinical notes, lab tests, pathology reports, messages, prescriptions, consultations, and secondary records.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If the patient is a minor (under 18 years of age), or if the patient has a legal guardian with the power of attorney, the responsible parent or guardian must sign above, and fill in the information below.

I am the parent of, or legal guardian of, or have the power of attorney for the forementioned patient, and consent to the matters set forth above, on behalf of the patient.

**Parent/Guardian Name (print):** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Mail this form to your previous dermatologist or treating physician at the earliest possible convenience, to improve the chance that your files will arrive in time for your appointment.  
Thank you.**