LEVY DERMATOLOGY

6254 Poplar Avenue
Memphis , TN 38119
PH: 901.624.3333
Fax: 901.624.1203

Medical Records Release Form

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE LEVY DERMATOLOGY TO:
(initial below)

_____ RELEASE INFORMATION TO:	_____ OBTAIN INFORMATION FROM:

_____
Name of Provider or Facility

_____
Address/City/State/Zip

_____
Phone Number Fax Number

Please initial specific information requested for release:

_____ Biopsy Results and/or Lab Reports – Specify, if applicable: _____

_____ Office/Surgical Notes – Specify, if applicable: _____

_____ All Protected Health Information (PHI) – All Records

_____ Other: _____

For the purpose of:

____ Continuing Care ____ Transferring Care ___ Other: _____

____ Personal ____ Physician

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Levy Dermatology.

I understand I may revoke this authorization at any time in writing and present my written revocation to Levy Dermatology. Unless otherwise revoked, this authorization will expire one year from the date signed below or as listed: ___/___/___.

_____ Date _____
Signature of Patient or Signature of Personal Representative

_____
Description of Personal Representative's Authority (Attach Necessary Documentation)

Revised December 2020.