



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: \_\_\_/\_\_\_/\_\_\_.

Signature of Patient or Signature of Personal Representative Date

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

East Memphis
6254 Poplar Avenue
Memphis, TN 38119
Fax: (901) 624-1203

Collierville
1125 Schilling Blvd. E. Suite 105
Collierville, TN 38017
Fax: (901) 457-7407

Cosmetic Center
6252 Poplar Avenue
Memphis, TN 38119
Fax: (901) 624-1203

Jackson
158 Murray Guard Dr.
Jackson, TN 38305
Fax: (731) 240-1415