STL Dermatology & Cosmetic Surgery

MEDICAL RECORDS RELEASE FORM

Patient Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____

City: _____ State: _____ Zip: _____

By signing this form, I authorize _____ (name of physician/facility) to release confidential health information about me, by releasing a copy of my medical records and/or summary or narrative of my protected health information to the physician/facility listed below.

The information you may release with this signed release form is as follows:

☐ Complete Record	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ Other: _____

Release my protected information to the following physician/facility:

St Louis Dermatology & Cosmetic Surgery
520 E. Cherry St.
Troy, MO 63379
Phone: (314) 834-1400 Fax: (314) 834-1430

This authorization will expire 6 months from the date signed unless otherwise specified. I understand that I may revoke this authorization in writing at any time

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient