Holmkvist MD. Dahl MD.
ACCREDITED DERMATOLOGY MEDICAL CLINIC INC.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Patient Last _____ First _____

Date of Birth _____ Phone (____)_____

Address _____

City _____ State_____ Zip Code _____

I hereby authorize and request the following doctor or medical facility:

Doctor or Medical Facility _____

Address _____

City_____ State _____ Zip Code _____

Telephone _____ Fax _____

to furnish my medical records to:

[ ] Accredited Dermatology Medical Clinic Inc.

[ ] Patient or parent of minor

[ ] Other Doctor or Medical Facility _____

Address _____

City_____ State _____ Zip Code _____

Telephone _____ Fax _____

Specific information requested:

___ Entire medical record
___ Pathology reports
___Other:_____
_____

I hereby authorize and request the following information as the:

___ Patient ___ Parent of the minor patient
___ Conservator of the patient ___ Guardian of the minor patient

Signature _____ Date _____

301 W. Bastanchury Road • Suite 245 • Fullerton, CA 92835 • P 714.525.3500 • F 714.525.3588