Holmkvist MD. Dahl MD.
Accredited Dermatology Medical Clinic Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME OF PATIENT: LAST__________________________FIRST_________________MIDDLE______________
DATE OF BIRTH__________________________________ PHONE (____)______________________________
ADDRESS____
CITY____ STATE _______ ZIP ___________________

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

NAME OF DOCTOR OR MEDICAL FACILITY: ____
ADDRESS ____
CITY____ STATE _______ ZIP ___________________
PHONE (_____) _________________________________ FAX (_____) ___________________________________

to furnish any and all information concerning my past and present medical history and condition to Accredited Dermatology Medical Clinic Inc. Specific information requested:

__ Entire medical record, including laboratory reports

__ Pathology slides and reports for all biopsies and surgical procedures

__Other:__________________________

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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 ___________________

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