Western New York Dermatology

## RELEASE OF MEDICAL RECORDS

Patient Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

DOB: _____

The undersigned, hereby consents to and authorizes the release by/to Michael Nazareth, M.D. all medical information, reports, progress or office notes concerning their medical or mental condition.

☐ Relevant records deemed pertinent by the treating physician

☐ Progress notes from_____ to _____

☐ Pathology reports from_____ to _____

☐ All records

☐ Other

Records requested are for the continuing of treatment.

I am authorizing the release of this information be sent from:

_____

I am authorizing the release of this information be sent to :

_____

This information is limited to the furnishing of the referenced records only and should not be used to communicate orally or for any other purpose than for my medical condition. This request will expire 60 days from date signed.

Signature: _____

Date: _____

The above named individual executed this authorization on the above referenced date and duly executed authorization.

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