Western New York Dermatology

Mohs Surgery
at Western New York Dermatology

Release of Medical Records

Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____

The undersigned hereby consents to and authorizes the release by/to Michael Nazareth, MD-PhD 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 continuation of treatment.

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

_____

I am authorizing the release of this information being 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 purpose other than for my medical condition.

Signature: _____ **Date:** _____

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

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