Signature Dermatology

Marya Cassandra, DO, FAOCD
Board Certified Dermatologist

Andrea Costanza, DO, FAOCD
Board Certified Dermatologist

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: ___ / ___ / ___ SS: _____ -_____ - _____

Address: _____ City/ State / Zip Code: _____

Phone Number: (____) _____ - _____ Email: _____

To release health care information of the patient named above to:

☐ **Self via encrypted email listed above** ☐ **Health care provider listed below**

Practice Name: _____ Physician/Practitioner Name: _____

Address: _____ City/ State / Zip Code: _____

Phone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

This request and authorization applies to: (Check One)

☐ Health care information relating to the following treatment, condition,

Or dates of treatment: _____

☐ Most Recent Bloodwork ☐ Pathology Report(s) for : _____

☐ Full Record

X_____ **Date:** _____

Signature of patient or patient's authorized representative

Katie Wang, DO, FAAD
Board Certified Dermatologist

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