Laing & Dimick
DERMATOLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name

Patient's Address

City, State, Zip Code

Patient's Date of Birth Phone Number

Patient's Social Security Number

I authorize:

Name of Physician, Institution, Clinic, Etc.

Address

City, State, Zip Code

☐ To release any and all of my medical records (as of the date of this release)

☐ To release any and all of my medical records except the following:

_____

To: **Laing & Dimick Dermatology**
2433 Oak Valley Drive, Suite 400
Ann Arbor, Michigan 48103

This information is effective for six months from the date of execution: however, it may be revoked by me at any time by providing notice in writing to the above named party.

Patient/Legal Guardian_____

Witness _____ Date _____