Marcia Cardelli, MD,
Traci Kimbrough, MD
Snehal Desai, MD

REQUEST FOR RELEASE OF MEDICAL RECORDS

To:____

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This is to authorize the release of patient's:

________ complete record

________ records of care from______________ to_______________ only

________ records of care concerning the following condition(s)

____

________ pathology reports: ____

________ other. Specify: ____

Patient's name: ____

Date of birth: ____

Please fax copies to: 248-267-5021 or Mail to: Affiliated Troy Dermatologists
4600 Investment Drive Suite 260
Troy, MI 48098

I understand the following: See CFR §164.508(c)(2)(i-iii)
a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

____
Signature of patient/patient's guardian date

____
Signature of witness date