GEORGIA SKIN&CANCER CLINIC

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MEDICAL INFORMATION RELEASE AUTHORIZATION

Patient's Name: _____

Date of Birth: _____ Social Security: _____

Requested From:

Facility: _____

Physician: _____

Phone: _____

Fax: _____

Released To:

Physician's Name _____

Phone _____ Fax: _____

Please Send the Following:

_____ All Medical Records _____ Lab Results _____ Pathology

_____ Other: _____

_____

Patient's Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

If patient is under 18 years of age