Akron	Green	Mayfield	Mentor
3624 W Market St.	1560 Corporate Woods Pkwy	5915 Landerbrook Dr, Ste 120	9485 Mentor Ave, Ste 102
Akron, OH 44333	Green, OH 44685	Mayfield Hts, OH 44124	Mentor, OH 44060
P: (330) 665-0555	P: (330) 871-9300	P: (216) 382-3806	P: (440) 266-5500
F: (330) 249-7230	F: (330) 249-7230	F: (330) 249-7230	F: (330) 249-7230

ALLIED DERMATOLOGY
AND SKIN SURGERY

Patient Authorization for Use/Disclosure of Protected Health Information (PHI)

Patient's Name: _____ DOB: _____
SSN: _____ Previous Name: _____

I request and authorize Allied Dermatology and Skin Surgery, LLC. to obtain/release healthcare information of the patient named above from/to:

Name: _____
Address: _____
City, State: _____ Zip Code: _____
Phone: _____ Fax: _____

I am aware that there may be information in this medical record that relates to **substance abuse, mental illness or HIV/AIDS**.

This request and authorization applies to:

☐ All healthcare information ☐ Consultation reports ☐ Operative Reports
☐ Lab Reports ☐ Pathology Reports ☐ Radiology Reports
☐ Physician Notes ☐ Other: _____
☐ Healthcare information relating to the following treatment, condition, or dates of treatment:
_____

I am aware that I can revoke this release at any time prior to the records being obtained/released from the above named entity. I understand this release is valid for 90 days from today's date.

_____ _____
Signature of Patient/Legal Guardian Date signed

_____
Relationship Status if signed by anyone other than the patient
(parent, legal guardian, personal representative, etc.)