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 or release healthcare information of the patient named above from/to:

☐ **Obtain** ☐ **Release**

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.)