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Akron, OH 44333
P: (330) 665-0555
F: (330) 249-7230

Green
1560 Corporate Woods Pkwy
Green, OH 44685
P: (330) 871-9300
F: (330) 249-7230

Mayfield
5915 Landerbrook Dr, Ste 120
Mayfield Hts, OH 44124
P: (216) 382-3806
F: (330) 249-7230

Mentor
9485 Mentor Ave, Ste 102
Mentor, OH 44060
P: (440) 266-5500
F: (330) 249-7230



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.)