DORSET STREET DERMATOLOGY

Mitchell Schwartz, M.D.
Phoebe Pelkey, PA-C
Kara Hankes, PA-C
Wendy Shedd, PA-C

AUTHORIZATION OF MEDICAL INFORMATION

Your medical records cannot be released until this form is completed and signed by the patient, parent, or legal guardian.

Please check appropriate box: □ Releasing medical information from this facility ***(fill out section A)***
□ Requesting medical information from another facility ***(fill out section B)***

Patient Information:

Patient Name: ______________________________

Today's Date: ______________ Date of Birth: ______________

Mailing Address: ______________________________
City *State* *Zip*

RELEASE OF MEDICAL RECORDS-SECTION A

Records to be released to (Name of Provider): ______________________________

Name of Facility: ______________ Phone: __________ Fax: __________

Address: ______________________________
City *State* *Zip*

Information to be released: ______________________________
Please provide dates if applicable

Patient Signature: ______________________________ Date: ______________

REQUEST FOR MEDICAL RECORDS-SECTION B

Records requested from (Name of Provider): ______________________________

Name of Facility: ______________ Phone: __________ Fax: __________

Address: ______________________________
City *State* *Zip*

Information to be released: ______________________________
Please provide dates if applicable

Patient Signature: ______________________________ Date: ______________

321 Dorset Street • South Burlington, Vermont 05403 • phone (802)660-8808 fax (802)660-4310