Holladay Dermatology & Aesthetics

Robert Topham, MD Kathryn Klossner, P.A-C

RELEASE OF RECORDS AUTHORIZATION

Patient's name: _____ Phone #: _____

Date of Birth: _____

I authorize the release of my records from:

Company:_____

Attention to:_____

Address: _____

Phone: _____Fax: _____

I authorize the release of:

☐ Medical records, dated _____ to _____

☐ Pathology/Lab reports

☐ Other information _____

Release this information to:

Company: _____

Attention to: _____

Address: _____

Phone: _____ Fax: _____

Patient/Guardian Signature: _____ Date: _____

Expiration Date of Authorization
This authorization is effective for six months unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Holladay Dermatology, 1775 E. 4500 S. Holladay, UT 84117.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent.