MONARCH
DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name_______________________________________ Date of Birth___________________________

Previous Name______________________________________ Social Security #_______________________

I request and authorize____ to release healthcare information of the patient named above to:

Name____

Address____

City___________________________________ State__________ Zip Code________________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Patient Signature____ Date ___________________________

THIS AUTHORIZATION IS VALID FOR ONE YEAR