Wolverine DERMATOLOGY
1673 Gezon Parkway SW Wyoming, MI 49519
Phone - 616-243-DERM (3376) Fax – 616-243-3377

RELEASE OF MEDICAL RECORDS

Patient Name:_____

Date of Birth: _____

Patient phone number: _____

By signing this form, I authorize:

Physician/Practice name:_____

Address:_____

City/State/Zip:_____

Phone number:_____

Fax number:_____

to release confidential health information about me, by releasing a copy of my medical records, or a summary of my protected health information, to Wolverine Dermatology. Phone: 616-243-3376, Fax: 616-243-3377

Information to be released (please check all that apply):

- **Complete records**
- **Pathology reports**
- **Laboratory reports**
- **Progress reports**
- **Procedure reports**

Purpose of this release of information:_____

Patient signature:_____

Patient name (printed):_____

Date signed:_____

Guardian signature:_____

Guardian printed name:_____

Relationship to patient:_____