Brookline Village Dermatology, P.C.
One Brookline Place Suite 406
Brookline, MA 02445

Authorization of Release of Medical Records/Medical Information

Patients Information: Date of Request ____/____/____

Name _____ D.O.B. ____/____/____

Address _____
Street City State Zip

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I authorize Brookline Village Dermatology, P.C. to release the following information.

____ **Entire Medical Record**

____ History/Progress Notes Dates: (_____)
From To

____ Lab Reports Dates: (_____)
From To

____ Pathology Reports Dates: (_____)
From To

____ AIDS/HIV Information Dates: (_____)
From To

_____
Physician Name or Name of Medical Practice

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

Signature of Patient_____

Signature of Witness_____

This is a routine request to help assist us in updating our medical record.