Brummitte Dale Wilson, M.D. & Associates

Dermatology, Mohs Surgery, Aesthetic & Laser Surgery

Brummitte Dale Wilson, M.D. ∗ Cornelie M. Jones, M.D. ∗ Peter SantaLucia, M.D.

Certified by the American Board of Dermatology

Patient Name ____ D.O.B. ___________
Address ____________________________________ City_____________ State_____ Zip_____

Re: *Release of Medical Records*

The undersigned, hereby consents to and authorizes the release by Brummitte Dale Wilson, M.D. & Associates and his employees, all medical information, reports, progress or office notes, hospital records, graphs, tracings, and x-ray films concerning my physical or mental condition, past and present, except as hereinafter limited.

The information to be disclosed shall be limited to the following: [REQUIRED]

FREE for up to 10 pages:

☐ Relevant Records deemed pertinent by your treating physician(s) from our Practice
☐ Pathology Reports - please specify biopsy/excision site ___________________ & approximate Date(s) _____/_____/_____

OR

75¢ per page (+ postage) for one of the options listed below:

☐ Progress Notes *(75¢ per page +postage)* - please specify Date Range _____/_____/_____ through _____/_____/_____
☐ Other *(75¢ per page +postage)* - please specify type of disease, accident, dates of treatment, or other portion of records in which you are interested ____

This disclosure is made for the following purpose: [REQUIRED]

____

I specifically authorize the release of this information to *(include address if applicable)*: [REQUIRED]

____
Address__________________________________ **City**________________ **State**______ **Zip**_________
or any person authorized by the above to examine any of the aforesaid records in your custody. This authorization is subject to written revocation at any time except to the extent that action has been taken in reliance thereon and shall in any vent expire on ____/____/20____ **(this authorization will automatically expire in 60 days if this field is left blank)**.

This authorization is limited to the furnishing of the above referenced records only and shall not be construed as authorizing you to communicate orally or in writing concerning my medical condition other than for the purpose of furnishing records. Acceptance of a photocopy of this authorization is hereby authorized.

______________________________________ ____/____/20____
Signature of Patient [REQUIRED] **Date [REQUIRED]**

WITNESS [REQUIRED] State of ___________ County of __________

On this ________ day of ___________________, 20_____, before me personally came ___________________________ known to me to be the individual above named who executed the foregoing authorization, and who duly acknowledged to me the execution thereof.

______________________________________ ____/____/20/____
Signature Of Witness [REQUIRED] **Date [Required]**

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