600 Suncrest Towne Centre, Suite 115
Morgantown WV, 26505
Phone 304-598-3888 Fax 1-304-721-4078

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION *TO* THE DERMATOLOGY CENTER FOR SKIN HEALTH, PLLC

Physician Name: _____

Practice Name: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

PLEASE FORWARD MY RECORDS TO THE DERMATOLOGY CENTER FOR SKIN HEALTH, PLLC:

_____ Dr. Michele Maouad _____ Dr. Rola Gharib _____ Kathryn Semans, PA-C

600 Suncrest Towne Centre, Suite 115
Morgantown, WV 26505
Phone: 304-598-3888. Fax: 1-304-721-4078

Please send the following information via FAX 1-304-721-4078:

PATIENT NAME: _____ DATE OF BIRTH: _____

CHECK ALL THAT APPLY:

_____ All Medical Records
_____ Pathology/Biopsy Reports
_____ Operative Reports
_____ Lab Reports
_____ Other: (Specify) _____

Patient Signature: _____ Date: _____

Parental Signature: _____ Date: _____
(if patient is under 18 years old)

Patient Representative (Print Name): _____ Relationship to Patient: _____

Patient Representative Signature: _____ Date: _____