Medical Release of Information

Patient Name (Please Print) ________________________**Phone#**________________

Date of Birth__________________________**Date**_____________________________

I authorize:____

To release my health information to: Vitality Integrative Skin Clinic LLC, Erin Bishop FNP-C

I specifically authorize the use or disclosure of the following health information:

___ALL MEDICAL RECORDS
___Radiology Reports_________from_______to _______
___Chart Notes ALL or from__________to___________
___Billing Statements
___Other (please list)____

Please fax to 1-888-972-4765

I understand that I may revoke this authorization at any given time by giving written notice. I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

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Signature of Patient or Patient's Legal Representative

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Print name of legal representative (if applicable)& Relationship of Legal Rep. to patient