AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: XXX-XX-________ (last 4 only)

I request and authorize ____ to release healthcare information of the patient named above to:

Dr. Elizabeth Hale and Dr. Julie Karen
CompleteSkinMD
225 East 64th Street
Second Floor
New York, NY 10065

This request and authorization applies to:

☐ Healthcare information relating to the following treatment(s) or specific dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Signature: ______________________ Date Signed: ______________________

Relationship: ____

225 EAST 64TH STREET
SECOND FLOOR
NEW YORK, NY 10065
212. 759. 4900
212. 759. 4800 FAX
completeskinmd.com