Dr. Michael W. Peterson, DO
732 North Main St. / Springville, UT 84663
P: (801) 704-7001 / F: (801) 210-7012
Email: springvillederm@gmail.com

Authorization for Release of Information from Springville Dermatology

Date:_____

I authorize Springville Dermatology and Diagnostics, PC to release copies of my medical records, with any restrictions noted, to the entity named below. Springville Dermatology will fax, or mail copies of these records to the entity as designated by me below.

To: _____

_____

_____

Restrictions:

- ○ No restrictions, including medical information obtained from other sources.
- ○ Pathology and/or lab test only.
- ○ Other _____

_____/____/_____

Print Patient Name — Date of Birth

_____

Patient Address — Phone Number

_____

Signature of Patient or Legal Guardian/Appointee