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 to Springville Dermatology

Date:_____

To: _____

_____

_____

I authorize the above named entity to release copies of my medical records, with any restrictions noted, to Springville Dermatology. Please fax, or mail copies of these records to the address above.

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