Yellowstone Dermatology

Authorization for release of information:

Full Name of Patient:______________________________ DOB:___/___/___

Address:______________________________Phone: ______________

I Hereby Authorize:_____Yellowstone Dermatology and Skin Cancer Clinic______________

Address:______2900 12th Ave N Suite 240W Billings, MT 59101______________

Phone:______(406) 238-6115__________Fax:______(406 238-6121______________

To Furnish to:____

Address: ____

Phone:______________________ Fax:______________________

The following data for dates__________ to __________/ ALL

________ Pathology

________ Lab data

________ Office notes

________ Other ______________________

________ Complete Medical Records

The undersigned individual by personal signature requests release of records as noted above.

Signature of Patient or Legal Guardian:

x____ Date: ___/___/___

Yellowstone Dermatology

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Address:______________________________Phone:____________

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Signature of Patient of Legal Guardian:

x______________________________ Date:___/___/____