



## Authorization for Release of Healthcare Information

Patient Name:		Date of Birth:	Date of Birth:	
I here	by authorize the transfer of the followi	ing healthcare information:		
FROM	1:			
TO:	Aesthetic Dermatology 3570 Grandview Parkway, Suite 100-B Birmingham, AL 35243 Tel: 205.588.7000 Fax: 205.621.9507	Shelby Dermatology 1022 First Street North, Suite 201 Alabaster, AL 35007 Tel: 205.621.9500 Fax: 205.621.9507		
	Entire contents of chart		_	
	OR			
	Progress notes			
	Pathology reports			
	Lab reports			
	Correspondence			
	Operative reports			
Pı	urpose of Disclosure:			
	Continuing Patient Care			
	Other			
and/c				
Signature of patient Date		te Signature of Parent/Guardian	Date	
 Witness	S Dat	te Relationship to Patient	 Date	