CLEAR
Dermatology & Aesthetics Center
Brenda LaTowsky, MD

Patient Full Name: _____

Date of Birth: _____/_____/_____

Previous/Other Name: _____
(If different than patient listed above)

This will authorize to release to/from:

_____

_____

_____

GENERAL INFORMATION REQUESTED

Medical Information Requested: Reason for Release:

- ☐ Complete Records
- ☐ To update my regular doctor (provider)
- ☐ Lab
- ☐ I have been referred to another doctor
- ☐ I want/need a second opinion
- ☐ I am changing doctor (provider)
- ☐ Dissatisfaction with care
- ☐ Other
- ☐ My insurance changed
- ☐ I am moving (New Address)

_____

_____

For the treatment period from _____ to _____

This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS:

The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Date: _____/_____/_____

Signature of Patient or
Responsible Name: _____

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