RELEASE OF MEDICAL INFORMATION

MEDICAL RECORDS ARE REQUESTED TO [ ] FROM [ ]

HERSCHEL E STOLLER, M.D.
CENTER OF DERMATOLOGY, P.C.
10110 NICHOLAS STREET, SUITE 103
OMAHA, NEBRASKA 68114-2185
(402) 398-9200 FAX (402) 398-9400

MEDICAL RECORDS BE RELEASED AND FORWARDED TO [ ] FROM [ ]

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THE FOLLOWING MEDICAL INFORMATION IS REQUESTED:

__ COMPLETE MEDICAL RECORDS

__ PATHOLOGY REPORT(S)

__ LAB WORK

__ OTHER

PATIENT NAME_____

DATE OF BIRTH_____

SOCIAL SECURITY NUMBER _____

SIGNATURE_____

DATE _____

AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE OF THE PATIENT SIGNATURE.

THIS AUTHORIZATION CAN BE REVOKED AT ANY TIME IN WRITING BY THE PATIENT EXCEPT IN THE CASES THAT THE MEDICAL INFORMATION HAS ALREADY BEEN FORWARDED PRIOR TO RECEIVING THE WRITTEN REVOCATION.