Kittridge Dermatology
Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____
Last First (MM/DD/YYYY)
Address: _____
Street City State Zip code

I hereby authorize Physician/Practice/Entity_____to release copies of the following portions of my medical record:

_____ Complete Medical Records: including all progress notes, pathology and lab reports
_____Other (please list): _____

These copies are to be released and sent/faxed to:

_____ Kittridge Dermatology
Attn: Dr. Ashley Kittridge, D.O.
101 Drake Road
Suite B
Pittsburgh, PA 15241
Fax#: 412-347-0948

_____Other:
Name of Physician/Practice/Entity:
_____

Complete Address:
_____

_____
Fax #:
(___ ___ ___)- ___ ___ ___-___ ___ ___ ___

This information is protected by state and federal laws. This authorization shall be valid for the next 6 months. I understand that this consent may be revoked in writing at any time.

Pennsylvania law prohibits Kittridge Dermatology from making any further disclosure of this information unless further disclosure is expressly permitted by written consent. A general authorization for the release of medical or other information is not sufficient for this purpose.

Patients signature: X _____Date: _____

Witness/Staff Person's signature: X_____Date: _____

If the patient is unable to consent or is a minor, complete the following:
Patient is a minor (_____ years of age) or is unable to provide a signature on this form.

X _____Date: _____
(Signature of parent, legal representative (legal guardian, executor or administrator of the estate)

Relationship to Patient: X_____ Date: _____

Witness Signature: X_____ Date: _____

KITTRIDGE DERMATOLOGY
101 DRAKE ROAD SUITE B, PITTSBURGH, PA 15241
P: 412-347-0947 F: 412-347-0948