FULL SPECTRUM
DERMATOLOGY
WILLIAM P. BAUGH, M.D.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This form must be filled out completely

Patient _____ Date of Birth _____
Print Name

Address _____

Day Phone _____ Evening Phone _____

Doctor or Facility Holding Records _____

Address City State Zip Code

Information To Be Sent To _____

_____

Address City State Zip Code

This information should include:

( ) Any and all information may be released, including but not limited to mental health records, drug and/or alcohol abuse records and/or HIV test results, if any.

( ) Copies of pertinent information only, described below:

( ) Any and all dates.

( ) Specific dates _____.

Signed: _____ Date: _____
If not signed by patient, please indicate relationship. Please furnish a copy of your Conservator/Guardian papers with this request.

333 W. Bastanchury Rd Suite 110, Fullerton, CA 92835 714-879-4312 * Fax 714-879-2154