**Mitchell Dermatology**
**815 Commerce Drive**
**Perrysburg, Ohio 43551**
**419.872.HOPE (4673)**
**Fax: 419.873.8329**

# Permission to Release Information

_____-_____-_____
**Date**

_____
**Patient**

_____-_____-_____
**Date of Birth**

_____
**Patient/Guardian Signature**

***Please check appropriate choice below**

☐ **I hereby give my permission for my medical records <u>to be released by</u> Mitchell Dermatology and forwarded to:**

☐ **I hereby give my permission for my medical records <u>to be forwarded to</u> Mitchell Dermatology from:**

_____
**Name of person/physician/facility**

_____
**Address**

_____-_____-_____
**Phone**

_____-_____-_____
**Fax**