65 Broadway Suite 904
New York, NY 10006

PATHOLOGY AND LAB REPORT RELEASE/AUTHORIZATION REQUEST

Patient's Name (Print): ____
Last First Middle

Date of Birth: ____/____/______ Home Phone: ________________________

Home Address: ____

I hereby authorize Wall Street Dermatology to release my pathology/lab report(s) to myself (or legal guardian). Please provide the requested information to me by (please choose appropriate option below):

___ pick-up at the office

___ have a copy of the requested information mailed to the following address:

____

____

____

X____ ____/____/______
Signature of Authorization of Patient or Legal Guardian **Today's Date**

____ __________________
Printed name of Authorization of Patient or Legal Guardian **Relationship to Patient**