Bayview Dermatology and
Cosmetic Surgery, S.C.

Neal Bhatia, M.D.
Diplomate, American Board of Dermatology

3119 S. Clement Avenue, Suite 100 • Milwaukee, WI 53207 • P: (414) 769 - 0040 • F: (414) 769 - 0048 • www.bayviewdermatology.com

Name______________________________
SS Number__________________________
Address____________________________
Telephone__________________________

Describe the specific purpose of the use or disclosure of the protected health information:

( ) Medical Record Transfer From ____________________
to Bayview Dermatology to: ____________________

( ) Medical Record Transfer From Bayview Dermatology to:

( ) Other (please describe)____________________

I have read the contents of this authorization and certify that the information stated therein this authorization is consistent with my direction. By signing this authorization I request the release and agree to permit disclosure of my protected health information as directed above. Please designate below the entity completing this form.

____ Patient
____ Personal Representative
____ Healthcare Surrogate

If a personal representative or healthcare surrogate completes this authorization on behalf of the patient who is the subject of the information, complete the following field:

Personal Representative/ Healthcare Surrogate Name:

Patient Signature: Date