Orchard Park Dermatology
ADULT SKIN CARE & SURGERY

Peter Accetta, M.D.
Susan Peterson, PA-C
Emily Gottstein, PA-C
Samantha Gomolka, PA-C

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Date: _____

To: _____
Physician Name

_____
Address City State Zip Code

I authorize the use or disclosure of my medical records to:

Peter Accetta, MD
Orchard Park Dermatology
3045 Southwestern Blvd Suite 104
Orchard Park, New York 14127

Phone #: 716-675-7000
Fax#: 716-674-4630

The type of information to be disclosed is as follows:

_____ Clinical Visit Notes _____ Entire Record

_____ Laboratory Reports _____ Pathology Reports

Any information including the diagnosis and records of any treatment or examination rendered to me.

_____ _____
Print Patient Name Date of Birth

_____
Signature

_____
Address City State Zip Code

_____
Witness