

DERMATOLOGY ASSOCIATES, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Your medical records cannot be released until this form is completed and signed by the patient or legal guardian. As you complete each step, check off the box at the left. There may be a processing fee associated with this request.

Step 1 Completed <input type="checkbox"/>	<p>STEP 1: <u>Patient Information</u> PLEASE PRINT!!</p> <p>PATIENT NAME _____ DATE OF BIRTH _____ Last First</p> <p>ADDRESS _____</p>
Step 2 Completed <input type="checkbox"/>	<p>STEP 2: <u>Disclosing Provider</u></p> <p>I hereby authorize: _____ M.D. Address _____ _____</p>
Step 3 Completed <input type="checkbox"/>	<p>STEP 3: <u>Information to be disclosed or released</u> To release the following information: Please specify:</p> <p><input type="checkbox"/> ALL RECORDS OR <input type="checkbox"/> ALL RECORDS EXCEPT _____ OR</p> <p><input type="checkbox"/> ONLY RECORDS RELATING TO _____ OR</p> <p><input type="checkbox"/> RECORDS OF TREATMENT FROM: _____ TO _____ OR</p> <p><input type="checkbox"/> OTHER _____</p>
Step 4 Completed <input type="checkbox"/>	<p>STEP 4: <u>Receiving provider and purpose of disclosure</u></p> <p>TO: _____ M.D. _____ _____</p> <p>FOR: _____ _____</p>
Step 5 Completed <input type="checkbox"/>	<p>STEP 5: <u>Statement of understanding and signature</u></p> <p>Your signature indicates that you agree to the disclosure or release of medical information described above <i>and</i> that you understand the following:</p> <ul style="list-style-type: none"> • This authorization is valid for 90 days from the date of signature. • You may revoke this authorization at any time by sending a written request for revocation to the provider named in Step 2 above. This revocation, however, will not affect any actions taken by the releasing provider before he/she received my written revocation. • Your medical treatment cannot and will not be dependent upon your signing this authorization. • The medical information that is the subject of this form may not be protected by the federal privacy regulations if or when it is redisclosed by the person, group, or institution you are authorizing to receive it. • You have the right to receive a copy of this authorization. • You have the right not to sign this authorization. <p style="text-align: right;">_____ Witness Signature</p> <p>_____ Patient's Signature / Parent's or Guardian's Signature _____ Date</p>
Step 6 Completed <input type="checkbox"/>	<p>STEP 6: <u>Sensitive Information:</u> (if applicable)</p> <p>I AGREE TO THE RELEASE of the information in my medical record that relates to drug and/or alcohol abuse, history of psychiatric care, history of sexually transmitted disease, social service consultations, hepatitis testing/treatment, and/or other sensitive information.</p> <p>_____ Signature of Patient or Legal Guardian _____ Date</p>
Step 7 Completed <input type="checkbox"/>	<p>STEP 7: <u>HIV Information:</u> (if applicable)</p> <p>IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.</p> <p style="text-align: center;">I AGREE TO THE RELEASE OF THE HIV INFORMATION IN MY MEDICAL RECORD.</p> <p>_____ Signature of Patient or Legal Guardian _____ Date</p>