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Board Certified Dermatologist

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I, \_\_\_\_\_ HEREBY AUTHORIZE THE

#### RELEASE OF PATIENT'S MEDICAL RECORDS TO:

DOCTOR/ CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

#### Please release the following:

- History / Physical Exam
- Progress Notes
- Biopsy/ Pathology Results
- Laboratory Results
- Clinical Images

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

- Yes, I consent to the release of this information
- No, I do not consent to the release of this information

#### Purpose of Disclosure:

- Treatment/ Continuing Medical Care
- Change of Physician
- Personal Use
- Attorney/ Legal
- Change of Insurance
- Others

I understand that I may revoke this authorization in writing at any time. otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signed this day: \_\_\_\_\_

Patient/ Parent / Guardian of Patient: \_\_\_\_\_

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