

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM:

Dermatology Affiliates, PC

P.O. Box 52226

Atlanta, GA 30355

Phone 404-816-7900 / Fax 404-816-7929

Please complete form thoroughly. Your medical records cannot be released until this form is completed and signed by the patient or legal guardian. Please make a check mark in the box provided at left as you complete each step on the form.

Step 1 Completed <input type="checkbox"/>	<p>TODAYS DATE: _____ PLEASE PRINT!</p> <p>STEP 1: Information about you</p> <p>Patient Name: _____ Date of Birth: _____</p> <p>Address: _____ <small>Street City State Zip</small></p> <p>Phone Number: _____ Alternate Phone: _____</p>								
Step 2 Completed <input type="checkbox"/>	<p>STEP 2: Who has the records now? PLEASE PRINT!</p> <p>I hereby authorize <u>Dermatology Affiliates, PC</u> M.D./D.M.D.(Circle One)</p> <p>Physician's Address: <u>PO Box 52226, Atlanta, GA 30355</u></p> <p>Phone/Fax: <u>404-816-7929</u></p>								
Step 3 Completed <input type="checkbox"/>	<p>STEP 3: To whom do you wish to release your records? PLEASE PRINT!</p> <p>I authorize release of all of the following information unless specifically checked below:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Complete Health Records</td> <td><input type="checkbox"/> Laboratory Reports</td> </tr> <tr> <td><input type="checkbox"/> Pathology Reports</td> <td><input type="checkbox"/> Lab & Pathology Reports</td> </tr> <tr> <td><input type="checkbox"/> Progress Notes Only</td> <td><input type="checkbox"/> Moh's Micrographic Surgical Notes</td> </tr> <tr> <td><input type="checkbox"/> Consultation Reports</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p>Dates of Treatment: _____ to _____</p> <p>Release to: Name _____</p> <p style="padding-left: 40px;">Address _____</p> <p style="padding-left: 40px;">_____</p> <p>Phone # _____ Fax # _____</p>	<input type="checkbox"/> Complete Health Records	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Lab & Pathology Reports	<input type="checkbox"/> Progress Notes Only	<input type="checkbox"/> Moh's Micrographic Surgical Notes	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Other: _____
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<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Other: _____								
Step 4 Completed <input type="checkbox"/>	<p>STEP 4: Your Signature</p> <p>This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for re-disclosure beyond stated time is required.</p> <p style="text-align: right;">_____</p> <p style="text-align: right;">Patient's Signature</p> <p>_____</p> <p>Witness Signature Parent/Guardian's Signature</p>								
Step 5 Completed <input type="checkbox"/>	<p>STEP 5: Release for Sensitive Information:</p> <p>I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.</p> <p>_____</p> <p>Signature of Patient or Legal Guardian Date</p>								
Step 6 Completed <input type="checkbox"/>	<p>STEP 6: Release of HIV Information:</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 align="center">I AGREE TO THE RELEASE OF THIS INFORMATION</p> <p>_____</p> <p>Signature of Patient or Legal Guardian Date</p>								

For Internal Use: Scan completed form into routing box, route to pt's chart as Pt Documents/ Request for DA's Medical Records, and send to NSN for signoff.