AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO:

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 ☐	**TODAYS DATE:** ________________ **PLEASE PRINT!** **STEP 1: Information about you** Patient Name:______________________Date of Birth:__________ Address:____ Street City State Zip Phone Number:________________Alternate Phone:________________
Step 2 Completed ☐	**STEP 2: Who has the records now? PLEASE PRINT!** I hereby authorize________________________M.D./D.M.D.(Circle One) Physician's Address: ________________________________ Phone/Fax: ________________________________
Step 3 Completed ☐	**STEP 3: To whom do you wish to release your records? PLEASE PRINT!** I authorize release of all of the following information unless specifically checked below: _____Complete Health Records _____Laboratory Reports _____Pathology Reports _____Lab & Pathology Reports _____Progress Notes Only _____Moh's Micrographic Surgical Notes _____Consultation Reports _____Other:______________ Dates of Treatment:______________to________________ Release to: Name___Dermatology Affiliates, PC__________ Address___PO Box 52226__________ ___Atlanta, GA 30355__________ Phone #__404-816-7900__________ Fax #__404-816-7929__________
Step 4 Completed ☐	**STEP 4: Your Signature** 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. ______________________ Patient's Signature ______________________ ______________________ Witness Signature Parent/Guardian's Signature
Step 5 Completed ☐	**STEP 5: Release for Sensitive Information:** 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. ______________________ ______________________ Signature of Patient or Legal Guardian Date
Step 6 Completed ☐	**STEP 6: Release of HIV Information:** 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. **I AGREE TO THE RELEASE OF THIS INFORMATION** ______________________ ______________________ Signature of Patient or Legal Guardian Date

For Internal Use: ☐ Faxed ☐ Mailed By Whom: ______________________

Scan form into pt's chart as Pt Documents/Requests for Other Med Records