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 ☐	**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__Dermatology Affiliates, PC_____M.D./D.M.D.(Circle One) Physician's Address: _PO Box 52226, Atlanta, GA 30355_____ Phone/Fax: _404-816-7929_____
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_____ Address_____ _____ Phone #_____Fax #_____
Step 4 Completed ☐	**STEP 4: Your Signature** This authorization is valid for this one time release. _____ _____ Signature of Patient or Legal Guardian Witness 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
Patient Rights	I understand that I have the right to revoke this authorization at any time. I understand that before signing this document I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

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