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.

<table>
<tr><td>Step 1 Completed ☐</td><td>TODAYS DATE: ________________ PLEASE PRINT!
STEP 1: Information about you
Patient Name: ________________ Date of Birth: ________
Address: ________________________________
Street City State Zip
Phone Number: ________________ Alternate Phone: ________________</td></tr>
<tr><td>Step 2 Completed ☐</td><td>STEP 2: Who has the records now? PLEASE PRINT!
I hereby authorize ________________ M.D./D.M.D.(Circle One)
Physician's Address: ________________
Phone/Fax: ________________</td></tr>
<tr><td>Step 3 Completed ☐</td><td>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___________</td></tr>
<tr><td>Step 4 Completed ☐</td><td>STEP 4: Your Signature
This authorization is valid for this one time release.
________________ ________________
Signature of Patient or Legal Guardian Witness Signature</td></tr>
<tr><td>Step 5 Completed ☐</td><td>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</td></tr>
<tr><td>Step 6 Completed ☐</td><td>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</td></tr>
<tr><td>Patient Rights</td><td>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.</td></tr>
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For Interal Use: ☐ Faxed ☐Mailed By Whom: ________________

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