Memorial DERMATOLOGY

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth: _____

Previous Name:_____ Social Security #:_____

I request and authorize Memorial Dermatology to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax#:_____

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition or dates:

_____

☐ X-Rays ☐ Laboratory/Pathology Reports ☐ Progress Notes ☐ Other_____

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person (s) listed above. I understand that the person (s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person (s) listed above.

This authorization shall be valid for 120 days from date of signature. The patient can revoke the authorization in writing at any time prior to expiration date. The patient agrees that a photocopy of this authorization may be considered valid. The patient understands that when this information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above name facility form all liability and damage resulting from the lawful release of my Protected Health Information.

_____ _____

Patient or Authorized Legal Representative Signature Date