Atlantic Dermatology Associates, P.C.
Dermatology and Dermatologic Surgery

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Authorization to Release Medical Records

First Name:	Middle Initial:	Last Name:
_____		
Date of Birth: _____		Phone: _____

I hereby authorize: (Facility) _____

Address: _____

Phone: _____ Fax: _____

Please release to:

Name: _____

Address: _____

City, State, Zip: _____

Phone#: _____ Fax#:_____

Dates of Service: ____/____/____ through ____/____/____

( ) Complete Medical Release ( ) Biopsy Reports(s) ( ) Lab Reports ( ) Consultation Report

( ) Medication Allergies ( ) Allergy Test/Treatment ( ) Surgical Procedures

( ) Other _____

I authorize release of my medical records and other information regarding my treatment including but not limited to, psychological or psychiatric impairment, drug abuse, alcoholism, sickle-cell anemia, acquired immunodeficiency syndrome (AIDS), or test for infection with human immunodeficiency. I authorize the Facility listed above to furnish the requested information, even though the confidentiality of the information may be protected by Federal or State law.

The Facility listed above and its staff are hereby released and discharged from any liability. I will hold the Facility listed above and its staff harmless for complying with this authorization to release medical information. Authorization will expire 60 days from date signed unless specified otherwise. Authorization can be revoked, but the withdrawal of authorization cannot be retroactive to release of information made in good faith.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Description of Personal Representative Authority (attach necessary documentation)