

Authorization to Release Medical Records/Information

Physician or facility to provide records: _____

Patient's Name: _____

Social Security #: _____

Person to receive records (name and address):

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition (s):

Initials

Initials

_____ Drug abuse if any

_____ Substance abuse if any

_____ Psychological or psychiatric conditions if any

_____ AIDS/HIV if any

Release these records:

Initials

- 1. Only records generated by this facility (not including records received from other sources)... _____
- 2. Only some portion of records maintained at facility (specify below)..... _____
- 3. All medical records at this facility..... _____

Expiration or revocation of authorization—I understand that I may revoke this authorization at anytime.

Use of copies—a copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print):

Person authorized to sign for patient:

Patient's Signature:

Signature:

Date

Relationship to patient

General & Cosmetic Dermatology
The Spa at Skin Care Specialists