

WHITE ROCK DERMATOLOGY

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RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I hereby authorize the release of information from the medical record of:

Patient _____ Date of Birth: _____

Social Security # _____ Daytime Phone: _____

INFORMATION RELEASED TO:

FROM:

For Healthcare covering the period(s) from _____ to _____

PLEASE RELEASE THE FOLLOWING:

_____ Chart Notes _____ Pathology Report(s) _____ Other (Specify) _____
including information (if applicable) pertaining to _____ HIV/AIDS

PURPOSE OR NEED FOR DISCLOSURE:

____ Continued Patient Care
____ Attorney/Legal
____ Disability Determination

____ Personal Use
____ Insurance Claim/Application
____ Other (Specify) _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness