Brentwood Dermatology
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Authorization to Release Medical Records/Information

Physician to provide records:_____

Patient's Name:_____

Social Security #:_____Date of Birth:_____

Person/Facility to receive records:_____

Address:_____

City/State/Zip:_____

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 (dates of treatment,etc. Specify below).... _____
3. All medical records at this facility..... _____

_____

_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Initials: Initials:

_____Substance abuse, if any _____AIDS/HIV, if any

_____Psychological or psychiatric conditions, if any

Other (Please Specify)_____

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

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: (PRINT)

_____ _____

_____ _____

Signature Signature & Relationship to Patient

Date:_____ Date:_____