AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO GEORGIA SKIN SPECIALISTS, P.C.

atient Legal Full Name:		Date of Birth: _	
Address:			
Phone Number:	Alternative I	Phone Number:	
authorize and request:			
	Name of doctor or facility with record	ls	
	Street Address		
	City	State	Zip
	Phone Number	Fax Number	
o release my records to: G	EORGIA SKIN SPECIALISTS, P.C.		
1800 Howell Mill R	oad NW, Suite 680, Atlanta, Georgia 30318	Phone : 404-352-1730	Fax: 404-352-6907
his request and authorizat	ion applies to: (PLEASE CHECK ONE)		
 	· · · · · · · · · · · · · · · · · · ·		
·	cal record(s), including treatment for menta	l illness, drug abuse, child ab	ouse, AIDS, or alcoholism
My complete medi		_	
My complete medi	cal record(s), including treatment for menta	_	
My complete medi	cal record(s), including treatment for menta	_	
My complete medi Healthcare informa Other (PLEASE SPE	cal record(s), including treatment for menta	ndition, or dates (PLEASE SPE	
My complete medi Healthcare informa Other (PLEASE SPEC	cal record(s), including treatment for mental ation relating to the following treatment, concepts: CIFY) his authorization may be revoked by me at a authorization to information that has alread	andition, or dates (PLEASE SPE	
My complete medi Healthcare informa Other (PLEASE SPECIAL I understand that t This revocation wo This authorization	cal record(s), including treatment for mental ation relating to the following treatment, concepts: CIFY) this authorization may be revoked by me at a culd not apply to information that has alread will expire one year from the date it was significant to the concepts of	andition, or dates (PLEASE SPE eny time. y been properly released. gned.	ECIFY)
My complete medi Healthcare information Other (PLEASE SPECIAL I understand that the standard standard that the standard standard that information, and medians.)	cal record(s), including treatment for mental ation relating to the following treatment, concluding treatment, concluding treatment, concluding treatment, concluding treatment, concluding the following treatment, conclude the following treatment, conclude the following treatment, concluding the following treatment, concluding the following treatment at a subject to the following treatment and the following treatment for mental health are concluded to the following treatment for mental health are concluded to the following treatment for mental are concluded to the following treatment for mental are concluded to the following treatment, concluding treatment for mental are concluded to the following treatment for mental are concluded to the following treatment, concluded to the following treatment, concluded the following treatment for mental are concluded to the following treatment for menta	andition, or dates (PLEASE SPE any time. y been properly released. gned. anclude information related to	ECIFY)
My complete medi Healthcare informa Other (PLEASE SPECIAL I understand that the standard sta	cal record(s), including treatment for menta ation relating to the following treatment, concerning the following treatment, concerning to the following treatment, concerning to the following treatment, concerning the following treatment, concerning to the following treatment, concerning the following treatment for mental ation relations to the following treatment for mental ation relations to the following treatment, concerning the following treatment the following trea	any time. y been properly released. gned. nclude information related to information. By signing belo	o HIV/AIDS, confidential w, I also specifically
My complete medi Healthcare information Other (PLEASE SPECIAL I understand that the standard that information, and mathorize the release of lunderstand that information information information information.)	cal record(s), including treatment for mental ation relating to the following treatment, concluding treatment, concluding treatment, concluding treatment, concluding treatment, concluding the following treatment, concluding the following treatment, concluding the following treatment, concluding the following treatment at a sufficient to the following treatment to the following treatment to the following treatment for mental with the following treatment for mental with the following treatment, concluding the following treatment, concluding treat	any time. y been properly released. gned. nclude information related to information. By signing belown may be subject to re-discle	o HIV/AIDS, confidential w, I also specifically
My complete medi Healthcare information Other (PLEASE SPECIAL I understand that the standard that information, and mathorize the releating my records and it records).	cal record(s), including treatment for mental ation relating to the following treatment, concluding treatment, concluding treatment, concluding treatment, concluding treatment, concluding the sale at a second that the sale and will expire one year from the date it was signiformation in my medical record that may in any include psychological and mental health are of this type of information. Information disclosed under this authorization hay no longer be protected by federal and starting that I have the authority to sign this form	any time. y been properly released. gned. nclude information related to information. By signing belown may be subject to re-discletate privacy regulations.	o HIV/AIDS, confidential w, I also specifically osure by the recipient of
My complete medi Healthcare information Other (PLEASE SPECIAL I understand that the standard that the standard that in information, and mauthorize the release of lunderstand that in my records and it in the standard that it is the	cal record(s), including treatment for mental ation relating to the following treatment, concepts of the following treatment of the following treatment, concepts of the follow	any time. y been properly released. gned. nclude information related to information. By signing belown may be subject to re-discletate privacy regulations.	o HIV/AIDS, confidential w, I also specifically
My complete medi Healthcare information Other (PLEASE SPECIAL I understand that the standard that in information, and mauthorize the release lunderstand that in my records and it my records and it my records and it may records and it may records and it may records and it may records and complete signature of Patient or signature of Patient or signature.	cal record(s), including treatment for mental ation relating to the following treatment, concepts of the following treatment of the following treatment, concepts of the follow	any time. y been properly released. gned. include information related to information. By signing below may be subject to re-discletate privacy regulations.	o HIV/AIDS, confidential w, I also specifically osure by the recipient of