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

Please complete this form thoroughly. Your medical records cannot be released until this form is completed and signed by the patient or legal guardian. **PLEASE PRINT LEGIBLY.**

Patient Legal Full Name: ____ Date of Birth: ______________________

Address: ____

Phone Number: _________________________________ Alternative Phone Number: ________________________________

I authorize and request: ____

Name of doctor or facility with records

____

Street Address

____

City State Zip

____

Phone Number Fax Number

To release my records to: **GEORGIA SKIN SPECIALISTS, P.C.**

1800 Howell Mill Road NW, Suite 680, Atlanta, Georgia 30318 **Phone**: 404-352-1730 **Fax**: 404-352-6907

This request and authorization applies to: (PLEASE CHECK **ONE**)

_____ My complete medical record(s), including treatment for mental illness, drug abuse, child abuse, AIDS, or alcoholism.

_____ Healthcare information relating to the following treatment, condition, or dates (PLEASE SPECIFY)

____

_____ Other (PLEASE SPECIFY)

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- I understand that this authorization may be revoked by me at any time.
- This revocation would not apply to information that has already been properly released.
- This authorization will expire **one year from the date it was signed.**
- I understand that information in my medical record that may include information related to HIV/AIDS, confidential information, and may include psychological and mental health information. By signing below, I also specifically authorize the release of this type of information.
- I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of my records and it may no longer be protected by federal and state privacy regulations.

By signing below, I certify that I have the authority to sign this form and that all information I have provided is true, accurate and complete.

____ ________________________________

Signature of Patient or Legal Representative Date Signed

____

Printed (Legible) Name of Patient or Legal Representative

If signed by Legal Representative, please provide the following information:

Relationship to Patient: ____