AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM 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: **GEORGIA SKIN SPECIALISTS, P.C.**
1800 Howell Mill Road NW, Suite 680, Atlanta, Georgia 30318
Phone: 404-352-1730 Fax: 404-352-6907

To release my records to: _____
Name of doctor or facility receiving records

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

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)

_____

- 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: _____