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

Alternative Phone Number: 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 o release my records to: Name of doctor or facility receiving records Street Address City State Zip Phone Number Fax Number his request and authorization applies to: (PLEASE CHECK ONE) My complete medical record(s), including treatment for mental illness, drug abuse, child abuse, AIDS, or alcohol 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. 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 in release of this type of information. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of 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	atient Legal Full Name:		Date of Birth:	
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If signed by Legal Representative, please provide the following information:		- ,		