

# Aesthetic Dermatology Associates, PC

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## Medical Records Release Authorization

### PATIENT INFORMATION:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Representative Name/Relationship: \_\_\_\_\_

### REQUEST RECORDS FROM:

Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

### PLEASE FORWARD RECORDS TO:

Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

### INFORMATION TO BE RELEASED:

- Entire medical record.
- Records of treatment from \_\_\_\_\_ to \_\_\_\_\_.
- Specific information (please list):  
\_\_\_\_\_  
\_\_\_\_\_

- By checking and signing here, I authorize the release of medical information related to mental health, HIV/AIDS, drug and alcohol abuse. Signature \_\_\_\_\_ Date \_\_\_\_\_

### Purpose of Release:

- Personal Information
- Insurance
- Medical Care
- Other \_\_\_\_\_

You may revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

I release Aesthetic Dermatology Associates, PC and it's physicians from all liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records.

The signature below authorizes release of the above medical information.

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date