## AL DERMATOLOGY PC

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## **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Please complete form thoroughly. Your medical records cannot be released until this form is complete and signed by the patient or legal guardian. Please make a check mark in the box provided at left as you complete each step on the form.

Step 1 Completed	STEP 1: Information about you:		PLEASE PRINT!
	Last First	Date of Birth:	
	Address: Street City	State ZIP	
Step 2 Completed	STEP 2: Who has the records now?		PLEASE PRINT!
	I Hereby authorize:	M.D./D.	.O/D.M.D. (Circle one)
	Physician's Address: Street C	ity State	ZIP
Step 3 Completed	STEP 3: To whom do you wish to release your records?  To release the following information: Please specify:  ALL RECORDS  OR		PLEASE PRINT!
	Dates of Treatment:OTHER:		
	TO:	M.D./D.	O/D.M.D. (Circle one)
Step 4 Completed	STEP 4: Your Signature  This authorization is valid from 90 days and may be revo		the expiration date.
	Patient's Signature	Date	
	Parent/Guardian's Signature	Witness Signature	
Step 5 Completed	STEP 5: Information about you:  I UNDERSTAN THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND /OR ALCOHOL ABUSE, PHYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.		
	Patient's Signature	Date	
Step 6 Completed	STEP 1: Information about you:  IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOU'RE HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.  I AGREE TO THE RELEASE OF THIS INFORMATION		
	Patient's Signature	Date	