Premier Dermatology
MEDICAL • SURGICAL • COSMETIC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE Premier Dermatology, P.C. to release the medical information to:

Name of receiving person/organization _____

Address _____

Telephone Number _____

Release Records Dating from: _____ TO _____

Purpose or need for disclosure:

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal

☐ Worker's Compensation Claim ☐ Personal ☐ Other: _____

I UNDERSTAND that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for a duplication of records. An estimate of charges will be provided upon request prior to duplication.

I UNDERSTAND that I may revoke this authorization at any time (in writing) except to the extent that action has been taken in reliance on it. To revoke this authorization, please provide a written statement to Premier Dermatology, P.C.

I AM AUTHORIZING and directing Premier Dermatology, P.C. to release my medical records which may include information regarding alcohol, drugs, mental health, sexually transmitted diseases, HIV, AIDS. I understand that this authorization will automatically expire twelve months from the date signed.

Patient's Name: _____ Patient's Date of Birth: _____

Present Mailing Address: _____

Daytime Telephone Number: _____

Patient/Legal Representative Signature: _____

Date: _____

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