

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Gwinnett Dermatology, P.C.
2383 Pate Street
Snellville, GA 30078
(770) 972-4845 • (770) 972-0358

*Please complete form thoroughly. Your medical records cannot be released until this form is completed 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 <input type="checkbox"/>	<p>STEP 1: Information about you: PLEASE PRINT!!</p> <p>Patient Name: _____ Date of Birth: _____ <small style="margin-left: 100px;">Last</small> <small style="margin-left: 100px;">First</small> <small style="margin-left: 100px;">MI</small></p> <p>Address: _____ <small style="margin-left: 100px;">Street</small> <small style="margin-left: 300px;">City</small> <small style="margin-left: 100px;">State</small> <small style="margin-left: 50px;">Zip</small></p> <p>Phone Number: _____ Alternate Phone: _____</p>								
Step 2 Completed <input type="checkbox"/>	<p>STEP 2: Who has the records now? PLEASE PRINT!!</p> <p>I hereby authorize _____ M.D./D.M.D. (Circle one)</p> <p>Physician's _____ Address _____</p>								
Step 3 Completed <input type="checkbox"/>	<p>STEP 3: To whom do you wish to release your records? PLEASE PRINT!!</p> <p>I authorize release of the following information:</p> <table style="width: 100%; border: none;"> <tr> <td>___ Complete Health Records</td> <td>___ Progress Notes Only</td> </tr> <tr> <td>___ Laboratory Reports</td> <td>___ Moh's Micrographic surgical notes</td> </tr> <tr> <td>___ Pathology Reports</td> <td>___ Consultation Reports</td> </tr> <tr> <td>___ Lab and Pathology Reports</td> <td>___ Other: _____</td> </tr> </table> <p>Dates of Treatment: _____ to _____</p> <p>Release To: Name: _____ Address: _____ _____ Phone #: _____ Fax #: _____</p>	___ Complete Health Records	___ Progress Notes Only	___ Laboratory Reports	___ Moh's Micrographic surgical notes	___ Pathology Reports	___ Consultation Reports	___ Lab and Pathology Reports	___ Other: _____
___ Complete Health Records	___ Progress Notes Only								
___ Laboratory Reports	___ Moh's Micrographic surgical notes								
___ Pathology Reports	___ Consultation Reports								
___ Lab and Pathology Reports	___ Other: _____								
Step 4 Completed <input type="checkbox"/>	<p>STEP 4: Your Signature</p> <p>This authorization is valid from 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond stated time is required.</p> <p style="text-align: right;">_____ Patient's Signature</p> <p>_____ Witness Signature</p> <p style="text-align: right;">_____ Parent/Guardian's Signature</p>								
Step 5 Completed <input type="checkbox"/>	<p>STEP 5: Release for Sensitive Information:</p> <p>I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.</p> <p>_____ Signature of Patient or Legal Guardian</p> <p>_____ Date</p>								
Step 6 Completed <input type="checkbox"/>	<p>STEP 6: Release of HIV Information:</p> <p>IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.</p> <p style="text-align: center;">I AGREE TO THE RELEASE OF THIS INFORMATION</p> <p>_____ Signature of Patient or Legal Guardian</p> <p>_____ Date</p>								