L. Terry Pynes, MD, FAAD
K. Lamar Hart, MD, FACOG
Patrick Nelson, PA-C
Administrator: Tina B. Pynes BS
Office Manager: Kendall Henderson BS
Nurse Manager: Amanda Woodham RN

DERMATOLOGY ASSOCIATES OF DOTHAN

2431 W Main St. Suite 501
Dothan, AL 36301-1274
Ph: 334-793-9222
Fax: 334-671-0322
info@dothanderm.com
Med Assist Manager: Margie Meredeth

Medical | Surgical | Cancer
Mohs Cancer Surgery | Radiation
Offices in Dothan AL, Enterprise AL, Eufaula AL, Troy AL, and Huntsville AL

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Guardian Name: _____ Social Security #: _____

I request and authorize **Dermatology Associates of Dothan** to release health care information of the patient named above to:

_____

_____

_____

This request and authorization applies to:

☐ Health care information relating to the following treatment, condition or dates: _____

_____

☐ All health care information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Authorization: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. This authorization will automatically expire upon satisfaction of the need for disclosure or on _____ (date)

Patient Signature: _____ Date Signed: _____