Augusta DERMATOLOGY AND AESTHETICS CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(REQUEST FOR RELEASE OF MEDICAL RECORDS)

Patient Name:_____ Date of birth: _____

By signing below you authorize :

Name:_____

Fax number:_____ to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period noted below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Please list the information that you are specifically requesting to disclose: _____

_____

Expiration date or expiration event of this request: _____

Name and mailing address of the person or entity to whom the information should be released:

Augusta Dermatology & Aesthetics Center

1224 Augusta W Pkwy , Augusta, GA 30909

706-922-0922

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised that any revocation will be effective only to the extent that we have not already taken action on your request. By signing below you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign this authorization.

Patient or Personal Representative's Signature:_____ Date:_____