AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION

I hereby authorize the release of all information contained in my medical records

**From:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician Name of Practice

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone Number Office Fax Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zip Code

 and send information contained in my medical records by standard mail post

 and send all information contained in my medical records by fax transmission

**To:** 

I UNDERSTAND THAT THIS AUTHORIZATION INCLUDES THE RELEASE OF CONFIDENTIAL INFORMATION WHICH MAY INCLUDE HIV RECORDS, PSYCHIATRIC MENTAL ILLNESS, DRUG/ALCOHOL ABUSE, VENEREAL DISEASE AND ANY OTHER STATUTORY PROTECTED DISEASES. I UNDERSTAND THIS CONSENT MAY BE REVOKED BY ME AT ANY TIME BY WRITTEN NOTICE UNLESS THE RECORDS HAVE ALREADY BEEN RELEASED. THIS AUTHORIZATION WILL EXPIRE NINETY (90) DAYS FROM DATE SIGNED.

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient Date of Birth (MM/DD/YYYY)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s Relationship to Patient Signature of Witness

**CONFIDENTIALITY NOTICE**

This transmittal is intended only for the use of the individual or entity to which it is addressed and *may* or *may not contain protected health information which strictly confidential.* This information may only be used or disclosed in accordance with federal law which contains penalties for misuse. If you are not the intended recipient of this transmission, you may not otherwise use or disclose the information contained in this transmission. **If you received this transmission in error, please return the transmission to MetroDerm, P.C. at 404-257-5531 and delete or destroy the information.** Thank you.