



# Authorization for Release of Medical Records

Print Patient Name		Patient DOB	
Street Address	City	State	Zip
Home Phone	Cell Phone		

**I authorize my health information to be released to:**

Provider/Facility	Address		
Phone	Fax		

**Description of information to be disclosed:**

- Entire Medical Record     
  Office Notes     
  Lab     
  Pathology     
  Radiology  
 General hospital or Outpatient Care     
  Other: \_\_\_\_\_

Specific date range of records to be released: From \_\_\_\_\_ to \_\_\_\_\_

**The purpose of this disclosure is:**

- Continuation of care / Referral to another provider     
  Personal use by patient  
 Transfer of care     
  Legal proceedings or insurance claim  
 Other \_\_\_\_\_

**This authorization will expire in one (1) year from the date signed below unless otherwise indicated:**

Specific date for expiration: \_\_\_\_\_

*This consent permits Brinton Lake Dermatology to use and disclose my protected health information to carry out treatment, payment or healthcare operations. As a patient, I have the right to request restrictions, uses and disclosures of health information in writing, at any time, except to the extent that action has already been taken. No further confidential information may be released without the execution of an additional written request. I understand these records are protected under Federal and State law and cannot be disclosed without my consent unless otherwise permitted by law. Having read the above information, I hereby RELEASE, AND HOLD HARMLESS, the practice, its employees, staff and agents in connection with the disclosure of information relating to these medical records.*

Print Patient Name	Patient DOB
Patient Signature	Date
Signature of legal representative/Guardian	Relationship