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DERMATOLOGY
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Medical, Surgical & Cosmetic Dermatology

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PATIENT AUTHORIZATION
FOR RELEASE OR REQUEST OF PROTECTED HEALTH INFORMATION

☐ I authorize Dermatology Center of Atlanta to release certain protected health information about me to: **the party indicated below**

_____
Physician/Third Party

_____
Address

_____

Phone (_____)_____-_____ Fax (_____)_____-_____

☐ I authorize the following party to release certain protected health information about me to: **Dermatology Center of Atlanta, 9900 Medlock Bridge Road, Johns Creek, GA 30097 Fax 770-497-0388**

_____
Physician/Third Party

_____
Address

_____

Authorized Information to Release:

- ☐ All of my medical records, including records obtained from other healthcare providers
- ☐ Pathology and/or lab tests only
- ☐ Other specifications: _____

By signing this release, I have authorized the above entity to disclose certain protected health information (PHI) about me to the indicated party. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. This authorization will expire upon completion or at such a time when I revoke it in writing.

_____ _____
Print Patient's Name Patient's Date of Birth

_____ _____
If applicable, Print Name of Legal Guardian Relationship

_____ _____
Signature of Patient or Legal Guardian Date

☐ Records released as indicated above by _____ on _____.
Employee Date

NOTE: PLEASE PRINT & COMPLETE THIS FORM. YOU CAN BRING THE FORM WITH YOU TO YOUR VISIT OR FAX THE COMPLETED FORM TO OUR OFFICE AT 770.497.0388.

IF A PATIENT'S MEDICAL RECORD IS MORE THAN 15 PAGES, PLEASE DO NOT FAX. PLEASE MAIL TO: DERMATOLOGY CENTER OF ATLANTA, 9900 MEDLOCK BRIDGE RD, JOHNS CREEK, GA 30097