Advanced Skin Institute
Cutting Edge Medical, Surgica and Cosmetic Dermatology
www.advancedskininstitute.com

Authorization to Release Medical Records

Patient Name:_____ **Date of Birth:** _____
First Middle Last (dd/mm/yyyy)

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct Advanced Skin Institute to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name and address of person(s)/entity to whom Advanced Skin Institute may disclose my health information.
Name:_____
Street Address:_____ City:_____
Phone:_____ Fax:_____

Information to be disclosed: This authorization permits Advanced Skin Institute to disclose the following medical records:
□ Lab Reports □ Pathology Reports □ Entire Chart □ Chart Notes (specify date(s) _____)

Term: This Authorization will remain in effect from _____ to _____.
(dd/mm/yyyy) (dd/mm/yyyy)

Redisclosure: I understand that once Advanced Skin Institute discloses my health information to the recipient identified above, Advanced Skin Institute cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by Advanced Skin Institute.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____
Patient Signature Date

If Patient is unable to sign this Authorization, please complete the information below:

_____ _____ _____
Guardian/Representative Relationship to Patient Date

_____ _____ _____
Witness Name Witness Signature Date