Family Dermatology
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MEDICAL RECORDS RELEASE FORM

Patient Name: _____

Date of Birth: _____ **Telephone Number:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Release Records From:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Tel: _____ Fax: _____

The specific information that I wish to have released is:
□ All Clinical Medical Records
□ Other Records – Please list (e.g. billing, photographs, etc.)

_____

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.
□ I consent to have the above information released.
□ I do not consent to have the above information released.

Signature: _____ **Date:** _____
(Parent or Legal Guardian of Minor)

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.
□ I consent to have the above information released.
□ I do not consent to have the above information released.

Signature: _____ **Date:** _____
(Parent or Legal Guardian of Minor)

I understand that this authorization is valid for a _____ day period from the date this is signed. I may revoke this consent at any time through written notice. If no expiration date is given for the authorization, the authorization will remain in force for one year.

Release Records to:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Witness Signature: _____ Date: _____