MEDICAL DERMATOLOGY SPECIALISTS
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB: _____

Email: _____

Daytime Telephone Number: _____ Patient of Dr. Ackerman / Dr. Kessler
Dr. Li / Dr. Zell

I authorize **Medical Dermatology Specialists, PC** to release medical records on the patient listed above to:

Name or Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

email address: _____

For the time period of: _____ to: _____

PLEASE CIRCLE WHICH OPTION: I request that the records be FAXED/ MAILED/EMAILED

OR PATIENT PICK UP DATE OF: _____ APPOINTMENT DATE: _____

CIRCLE Purpose of this request:

Continuing Medical Care

Insurance Billing

Personal

Other: _____

CIRCLE Information being requested:

Progress/Office notes

Pathology Reports

Laboratory Reports

Radiology Reports

Other: _____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. The request for revocation must be in writing to the office address listed below. I understand that if information is disclosed to a third party, the information may no longer be protected by the Privacy Rule and could be released by the person or organization that receives the information.

This authorization will expire one year from the date signed below. Medical Dermatology Specialists may not condition treatment on whether this authorization is signed.

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), sexually transmitted Disease, behavioral health care/psychiatric care, and treatment of alcohol &/or drug abuse; my signature authorizes the release of any such information.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient (if not patient): _____