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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name_____ **DOB**_____

Telephone Number_____

I authorize Gwyn Londeree, M.D./Kristin Abbruzzi, PA-C, MPAS of Encore Dermatology:
Check one:
To release my medical records to: To obtain my medical records from:

Name: _____

Address: _____

Fax # (if known): _____

The following medical information regarding my care and/or treatment on the following dates (required):_____ to _____

All Records Pathology Reports Laboratory Reports

Other (please specify)_____

Purpose of Disclosure:

Transfer of Care Other (please specify)_____

I hereby authorize the treatment facility indicated above and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of an HIV test or the fact that an HIV test was performed. Information in the form of photo(s) or video has been designated above, if applicable. I expressly consent to the release of information designated above. The authorization is valid for 60 days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. The revocation of this authorization is effective except as indicated in Encore Dermatology's Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA. I understand that Encore Dermatology cannot condition my treatment or payment for health care on this authorization unless the treatment is research-related or the care was provided solely to provide information for a third party.

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT | **DATE**

RELATIONSHIP, IF NOT PATIENT