ADVANCED DERMATOLOGY & SKIN SURGERY, PA

Authorization for Release of Medical Information

Today's Date: _____

Patient's Name: _____

Date of Birth: _____ SSN: _____

I hereby authorize Advanced Dermatology and its employees to ☐ **release** or ☐ **obtain** (please check appropriate box) information pertaining to my medical care and treatment, including, but not limited to, mental health records, drug and alcohol abuse records and diagnosis and/or treatment of HIV (Aids Virus).

I request my medical records ☐One year ☐Two years ☐Entire chart ☐Other (specify) _____

Release to:	**Obtain from:**
_____	_____
_____	_____
_____	_____

I understand that I may revoke this consent at any time, and that upon fulfillment of the above stated purpose or lapse of twelve (12) months from the date of signature, whichever comes first, this consent will automatically expire without my express revocation, but that revocation may not be applied retroactively once the information has been released in good faith. **I understand that Advanced Dermatology and its staff and employees cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release them from any liability arising from such disclosure and from all legal responsibility or liability that may arise from this authorization.**

Signed: _____ Date: _____

Witness: _____ Date: _____

If not signed by the patient, please indicate relationship:

□ Parent or guardian of minor patient

□ Guardian or conservator of an incompetent patient

□ Beneficiary or personal representative of deceased patient

Please email completed form to medicalrecords@adssnc.com.
Please allow 30 days for processing of medical records.