Aesthetic Dermatology Associates, PC

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Paoli Pa 19301
Tel:610-647-4161
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Medical Records Release Authorization

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Representative Name/Relationship: _____

REQUEST RECORDS FROM:

Name/Facility: _____

Address: _____

PLEASE FORWARD RECORDS TO:

Name/Facility: _____

Address: _____

Fax: _____

INFORMATION TO BE RELEASED:

- ❑ Entire medical record.
- ❑ Records of treatment from _____ to _____.
- ❑ Specific information (please list):

  _____

  _____

- ❑ By checking and signing here, I authorize the release of medical information related to mental health,

  HIV/AIDS, drug and alcohol abuse. Signature_____ Date_____

Purpose of Release:

- ½π Personal Information
- ½π Medical Care
- ½π Insurance
- ½π Other _____

You may revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.
Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

I release Aesthetic Dermatology Associates, PC and it's physicians from all liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records.

The signature below authorizes release of the above medical information.

_____ _____

Patient or Representative Signature **Date**