

**Authorization for Release Of Medical Records**

**Date Of Request:**

**Patient's Name** \_\_\_\_\_ **Date Of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State/Zip:** \_\_\_\_\_

**Patient's Social Security Number : (REQUIRED For All Requests):** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Patient's Contact Number:** \_\_\_\_\_

<input type="checkbox"/> I authorize Atlanta Skin Cancer Specialists to release my information to:  _____ <b>Name of Provider/Facility</b>  _____ <b>Address:</b>  _____ <b>City, Sate and Zip Code:</b>  _____ <b>Office Number and or Fax Number:</b>	<div style="border: 1px solid black; background-color: orange; padding: 5px; width: 40px; margin: 0 auto;">OR</div>	<input type="checkbox"/> I authorize Atlanta Skin Cancer Specialists to obtain my information from:  _____ <b>Name of Provider/Facility</b>  _____ <b>Address:</b>  _____ <b>City, State and Zip Code:</b>  _____ <b>Office Number and or Fax Number:</b>
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**Information To Be Released: (Check all applicable categories)**

- |  |  |
|--|--|
| <input type="checkbox"/> Complete Copy Of All Records    | <input type="checkbox"/> Itemized Invoices/Bills         |
| <input type="checkbox"/> Telephone/verbal Communications | <input type="checkbox"/> Counseling & Consultation Notes |
| <input type="checkbox"/> Lab/Pathology Reports           | <input type="checkbox"/> Other: _____                    |

**Purpose Or Need For Disclosure: (Check all applicable categories)**

- |   |  |
|---|--|
| <input type="checkbox"/> For Further Medical Care         | <input type="checkbox"/> For Payment Of Insurance Claims |
| <input type="checkbox"/> Application For Insurance Policy | <input type="checkbox"/> Legal Investigation             |
| <input type="checkbox"/> Disability                       | <input type="checkbox"/> Other: _____                    |

**Patient Disclaimer-** I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to this office, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical provider covered by privacy regulations, the information stated above could be redisclosed.
- There may be a charge for this records request.
- I have the right to inspect the medical information which I am authorizing, with certain exceptions provided under state and federal law.

Signature Of Patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_