AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

North Atlanta Dermatology

3850 Pleasant Hill Road
Duluth, GA 30096
Phone #: 770-814-8222 FAX #: 678-205-5111

PLEASE ALLOW 7-10 DAYS FOR PROCESSING
Note: A fee may be required to process medical records

Step 1	Step 1: **INFORMATION ABOUT PATIENT:** **PLEASE PRINT!** Patient Name:_____ Date of Birth:_____ Last First MI Address:_____ Street City State Zip Phone #_____ Alternate Phone # _____
Step 2	Step 2: **WHO HAS RECORDS NOW?** **I hereby authorize**_____M.D./Practice **Phone #:_____ FAX #:_____** **I authorize release of the following information to party listed in step 3:** **(All records to be sent if left unspecified)** **___Complete Health Record** **___ Progress Notes Only** **___Laboratory Reports only** **___Pathology Reports only** **___Other:_____** **Dates of Treatment:_____ to _____ All:_____**
Step 3	Step 3: **TO WHOM DO YOU WISH TO RELEASE YOUR RECORDS?** **Release To: Name:_____** **Address:_____** **Phone #_____ FAX #_____**
Step 4	Step 4: **SIGNATURE** I understand this authorization includes release of medical records including HIV records, Psychiatric, Mental Illness, Drug/Alcohol abuse, STD related information and any other statutory protected diseases. This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. The information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may no longer be protected by the federal privacy regulations. _____ _____ _____ Signature Date _____ Printed Name _____ Relationship to Patient
Step 5	**Employee to complete**: Pt. #_____ Initial: _____ Date:_____

Please complete form thoroughly. Records cannot be released until this form is completed and signed by the patient or legal guardian

Rev. 1/24/17