DERMATOLOGY LTD

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S SIGNATURE (REQUIRED): _____ DATE: _____
(Or Parent / Guardian's Signature for Minor Children)

I AUTHORIZE DERMATOLOGY, LTD

_____ **TO RELEASE MEDICAL INFORMATION TO:**

DOCTOR / HOSPITAL, ETC. _____

STREET / CITY / STATE / ZIP _____

_____

PHONE NUMBER _____ FAX NUMBER _____

_____ **TO OBTAIN MEDICAL INFORMATION FROM:**

DOCTOR / HOSPITAL, ETC. _____

STREET / CITY / STATE / ZIP _____

_____

PHONE NUMBER _____ FAX NUMBER _____

_____ ENTIRE MEDICAL RECORD _____ LAST FIVE (5) YEARS SPECIFY _____

Each patient has the right to restrict disclosure for services the patient paid for out of pocket. This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-related Information Act.