Commonwealth Dermatology P.S.C
2351 Huguenard Drive
Lexington, KY 40503

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Patient's Name	Date of Birth	Account/Chart Number

HEREBY AUTHORIZE:
(Name and Address of Releasing Facility)

_____

_____

_____

TO RELASE INFORMATION TO:
(Name and Address)

_____

_____

_____

REASON:

_____ Patient's Own Review

_____ Payment of Claim

_____ Litigation

_____ Continuation of Care

_____ Transfer of Care to another Dermatologist

_____ Other (Please Specify)

TYPE OF INFORMATION TO BE RELEASED:

_____ Physician Notes

_____ Laboratory Reports

_____ Between Dates of _____ to _____

_____ Only Records of Dr. _____

_____ Therapy Notes

_____ Operative Notes

Other (Please Specify) _____

I understand that this authorization will remain in effect 1 (one) year from the date of the signature. I also understand that it may be revoked by me, in writing at any time, but would not apply to any information already released to good faith.

Signature or mark of patient, parent of minor, or legal guardian representative	Date

If patient is unable to sign, the person signing the authorization will be required to show proof of guardianship or other authority and relationship to patient allowing him/her to authorize the release of medical information. All sections of this authorization must be complete. INCOMPLETE AUTHORIZATION WILL NOT BE ACCEPTED.

THE RELEASE OF RECORDS OR INFORMATION MAY BE SUBJECT TO CHARGE