Dermatology Specialists of Alabama, Florida, Georgia & Mississippi
Southeastern Dermatology Group, P.A. | Dermatology Specialists of Georgia, LLC
♦Aqua Medical Spa ♦30A Plastic Surgery ♦The Hair Transplant & Restoration Center ♦877.231.3376

MEDICAL RELEASE CONSENT (Complete all sections to prevent delays. Allow up to 14 business days for request to be processed.)

_____ _____ xxx-xx-_____
Patient Legal Name: Birth Date: Social Security No.

_____ _____
Patient Address Telephone No.

_____ _____ _____
City State Zip Code

For Disclosure Only
I hereby authorize _____
Name of Physician and/or Practice Name to Release Records

_____
Address

_____ _____
Fax Number Telephone Number

To disclose medical record information and/or protected health information of the patient listed above to:

_____ _____
Name of Physician and/or Practice Name/Individual/Organization to Receive Records Telephone Number

_____ _____
Address Fax

Purpose: _____

Type of Access Requested :

- □ Copies of the record
- □ Inspection of the record
- □ Entire Record

Select Portions of Personal Health Information :

- □ Emergency Room
- □ History & Physical
- □ Consult Report
- □ Operative Report
- □ Lab
- □ Imaging / Radiology
- □ Demographics
- □ Progress Notes
- □ Medication Record
- □ Path Report
- □ Physician Orders
- □ Billing Records
- □ Other_____

Expiration: This authorization shall expire in one year unless otherwise specified below:

- □ Fulfillment of this request (according to HIPAA or State Regulations, whichever is shorter)
- □ Date _____ (Not to exceed one year)

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. Fees/changes will comply with all laws and regulations applicable to release of information. Power of Attorney (POA) must be attached if signing as POA.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____ _____
Date Signature of Patient/Responsible Party Relationship to Patient

_____
Address and telephone number of Requestor (if different from patient information)