Advanced ✷ Dermatology

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Authorization of Release of Confidential Information

Date:_____

Patient's Name: _____ Date of Birth: _____

I hereby authorize Advanced Dermatology, LLC and its staff to **OBTAIN** the following Information **from**:_____

Address:_____

_____

Tel: _____ Fax: _____

I hereby authorize Advanced Dermatology, LLC and its staff to **RELEASE** the following information **to**:_____

Address:_____

_____

Tel: _____ Fax: _____

I am authorizing this release for the purpose of:_____

Initial the Specific Information to be disclosed:

____ Medical/ Clinical/ Surgical Notes Date(s): _____
____ Laboratory/ Pathology Reports Date(s): _____
____ Correspondence Notes Date(s): _____
____ Medical History
____ Notes related to HIV/AIDS
____ Notes related to Psychiatric Conditions
____ Other (specify):_____
____ Exclusions (specify):_____

AUTHORIZING SIGNATURE:_____

DATE OF SIGNATURE:_____

Explain relationship if signature is any other than the patient: _____

Note: The confidentiality of medical information, psychiatric information and /or HIV/AIDS testing information is required under the Connecticut State Statues, Chapter 899, Section 52-146 and 89-246. This information cannot be transmitted to anyone else without explicit consent or through other authorizations as provided in the statutes of the State of Connecticut.

_____
Release Signature