AFFILIATED TROY DERMATOLOGISTS

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# REQUEST FOR RELEASE OF MEDICAL RECORDS

Records being sent from Affiliated Troy Dermatologists

This is to authorize the release of patient's:

_____ complete record

_____ records of care from_____ to_____ only

_____ records of care concerning the following condition(s)

_____

_____ pathology reports: _____

_____ other. Specify: _____

Patient's name:_____

Date of birth:_____

Records to be sent to:_____

_____

_____

I understand the following: See CFR §164.508(c)(2)(i-iii)
a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____

Signature of patient/patient's guardian date

_____

Signature of witness date