



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

