PMS ID

NEWNAN • PEACHTREE CITY • WEST GEORGIA

DERMATOLOGY

Authorization for Use or Disclosure of Protected Health Information to Dermatology Specialists of West Georgia, P.C.

I authorize the Medical Record Custodian of _____ to release information from the medical record of:

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Date(s) of Service: _____

Information May Be Released To: Derm Specialists of West GA, PC

_____
Dermatology Specialists of West Georgia, P.C. Provider

_____
Dermatology Specialists of West Georgia, P.C. Location

_____
Address, City, State, Zip

_____ _____
Phone Fax

Information Will Be Released From:

_____
Practice/Doctor

_____
Address

_____
City, State, Zip

_____ _____
Phone Fax

Please release the following information:

- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Other (specify records needed): _____
- ☐ Laboratory Reports
- ☐ All Records

Purpose of Request or Disclosure (check one): *Please list the reason or purpose for the release***:**

- ☐ Continued Patient Care
- ☐ Attorney/Legal
- ☐ Other: _____
- ☐ Insurance Claim/Application
- ☐ Change of Physician/Relocation
- ☐ Personal Use

I understand that the information released is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I will not hold any employee of Dermatology Specialists of West Georgia, P.C. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

_____ _____ _____
Signature of Patient Relationship to Patient (self, parent, spouse) Date