PMS ID

WEST
GEORGIA
DERMATOLOGY

Authorization for Use or Disclosure of Protected Health Information to West Georgia Dermatology

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: WEST GEORGIA DERMATOLOGY

____
West Georgia Dermatology Provider

____
West Georgia Dermatology 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
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ All Records
- ☐ Other (specify records needed): ____

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

- ☐ Continued Patient Care
- ☐ Insurance Claim/Application
- ☐ Attorney/Legal
- ☐ Change of Physician/Relocation
- ☐ Other: _____________________________
- ☐ 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 West Georgia Dermatology 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