

Authorization for the Release of Medical Record Information from or to Anne Arundel Dermatology, P.A.

irom or to Anne Arundei Dermatology, P.A.				
Patient Full Name (If name has changed, please specify.)		Date of Birth		
Street Address		City/State/Zip		
Home Phone		Cell Phone		
The above patient or his/her or hor to make a disclosure of medic Disclosed By: AAD or (): Name – (e.g. Health Facility, Physicia	al record information as fo	llows: Disclosed	To: □AAD or ():	P.A., practice locations, to reques
Address		Address		
City State	Zip Code	City	State	Zip Code
Type of Information to Disclose: (Check all that apply) □ Entire Record □ Visit of(date) □ Pathology Results only □ Blood Test Results only □ Culture Test Results only □ Billing information only		The Purpose of this Disclosure is: (Check all that apply) Change of Insurance or Physician Continuation of Care Referral Personal Records Other: Check if you would like records mailed Check if you would like records faxed FAX NUMBER:		
Restrictions: Only medical records or authorization is valid only for the relespecified.				

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules once redisclosed. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure from the Anne Arundel Dermatology Office.

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I understand copy fees may apply.

Signature of Patient	Date
Signature of Parent/Guardian or Authorized Representative	Date
Printed Name of Parent, Guardian or Authorized Representative	Relationship to Patient (Representatives: Attach proof of such status)
Address of Authorized Representative or Guardian	Telephone Number