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Authorization to Release Medical Records

Georgia Skin Specialists, PC

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Patient Name [please print]: ____Date of Birth: _____________

Patient's SSN: _________________________

This request and authorization applies to: (please check one)

___My complete medical record(s), including treatment for mental illness, drug abuse, child abuse, aids, or alcoholism.

___Healthcare information relating to the following treatment, condition, or dates (please specify).

____

___Other (please specify)

____

I hereby request and authorize ____, or their physicians, to release the above stated protected health information to:

____

____

____

____

Patient Signature: ____ Date: ______________

-OR-

Patient Representative's
Name [please print]: ____

Relationship to Patient: __ Parent __ Legal Guardian __ Person with Power of Attorney

Signature: ____Date: ______________