AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient:_____ **DOB:**_____

Address:_____

I authorize Embrace Dermatology and Aesthetics, LLC to:
___ Send copies of my record to (or discuss information with) the provider/person/facility below

OR

___ Receive copies of my record from (or discuss your information with) the provider/person/facility below.

Name of Provider/Person/Facility: _____
Address: _____
City/State/Zip: _____

Phone: __(____)_____ Fax: __(____)_____

Information to be disclosed: _____Progress Notes _____Pathology/Lab Report(s) _____Operative Notes _____Cosmetic Notes

_____Entire Medical Record

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. There may be a charge for the requested records according to PA State Law. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to Embrace Dermatology and Aesthetics, LLC.

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.

Patient/Representative Signature: _____**Date:** _____
Parent/Guardian signature required for minor (less than 18 years of age)
Relationship to patient (if other than self): _____
Printed name of Authorized Representative: _____