Authorization to Release Health Information
Advanced Dermatology of Southern Maryland

Patient Information:

Name of Patient ____ Date of Birth _____________

Address____

City, State, Zip ____Phone ____________________

At my request the following information may be released:

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes
- ☐ Marketing*
- ☐ On site record review by the patient
- ☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
- ☐ Diagnostic studies (list):
- ☐ Other as listed

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name ____

Address____

City, State, Zip ____Phone ____________________

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

____Date ______________________

Signature of Patient or Personal Representative

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Description of Personal Representative’s Authority (attach necessary documentation)

Revised August 2013