PALOMA DERMATOLOGY LLC
AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

PATIENT INFORMATION
Patient Name_____
Former Name (if applicable)_____
Date of Birth_____
Phone Number_____

INFORMATION TO BE RELEASED FROM
I hereby authorize (name of organization) _____
To release the following medical information contained in patient's medical record

TYPE OF INFORMATION TO BE RELEASED (No information will be released unless the box is checked)
General Release

- ☐ Medical Records From:_____ To:_____
- ☐ Medical Records/Excluding Protected Records selected below From:_____ To:_____
  Information Protected by State/Federal Law
  Please exclude checked boxes
  - ☐ HIV Test Results
  - ☐ Alcohol and Drug Therapy
  - ☐ Mental Health Treatment Records

PURPOSE FOR THE REQUEST (Please check a box)
☐ Doctor ☐ Insurance ☐ Attorney ☐ Other

INFORMATION TO BE RELEASED TO
Name of Physician/Organization_____
Street Address_____
City/State/Zip_____
Phone Number_____

This is: ☐ One-time Disclosure ☐ Continuing Disclosure for 12 Months

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that I may revoke this authorization in writing at any time, except to the extent that the release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breech of my right to confidentiality.

_____ _____ _____
Signature of Patient or Legal Representative Date Please Print name of Signing Party