Gem State Dermatology, P.A.

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize_____ to disclose the following information from my health records for the purpose of continuation of medical care and or treatment to the following recipient:_____

Patient Name: _____ Date of Birth: _____

Information to be released:

( ) All of my health information
( ) Mole mapping/photography
( ) Pathology Report(s)
( ) Progress Note(s)
( ) Laboratory Report(s)
( ) Other _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on authorization. Unless otherwise revoked, this authorization will expire 90 days from the date the authorization was signed. The facility, its employees, officers and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed_____ Date _____

Legal representative (relationship to patient) _____

Witness_____ Date _____