METRO DERMATOLOGY
Trust your skin to us

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I request and authorize from Metro Dermatology of NY, P.C. / Metro Dermatology of NJ, P.C. to release health care information of the patient named below.

Patient Name: Date of Birth:
Patient Contact: Phone:
Email:

Send records to

Recipient's Name: _____
Recipient's Phone #_____ Fax#_____
Address:_____
_____

*****(If recipient is Physician: Name, address, phone number or fax number)**
*****(If recipient is patient, Name, address or email address. NO FAX)**

Information to be Release/Obtained: Copy of and/or information from my medical file pertaining to my evaluation and treatment received from _____ to _____

This is to include ___ Complete Record ___Lab/Pathology Results only ___Consultation Note

This authorization is valid for 180 days from the date of signature and there will be fees to process it.
The patient can revoke this authorization at any time by notifying the practice in writing. This would not affect any actions already taken by the practice based upon this authorization.
I understand that I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment or eligibility). However, I do have to sign it to receive health care when the purpose is to create health information for a third party or take part in research study.
Once health care information is disclosed, the person or organization that receives it may re-disclose it and our practice will not be responsible for this release. The Privacy laws may no longer protect it.
I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL, DRUG, AND PSYCHIATRIC TREATMENT, AIDS AND/OR HIV TESTINGAND/OR OTHER SEXUALLY TRANSMITTED DISEASES. I UNDERSTAND THIS INFORMATION WILL BE RELEASEDUNLESS I SPECIFICALLY REQUEST THAT IT BE WITHHELD.

_____ Date_____
Signature of patient or patient's authorized representative Date signed

_____
Relationship if signed by anyone other than patient (parent, legal guardian, etc.)

Office Staff Signature Date released