METRO DERMATOLOGY

AUTHORIZATION TO REQUEST MEDICAL INFORMATION

Name of Patient: _____ Date of Birth: / /

Phone: _____

I request and authorize (previous Doctor - please include address and phone number)

_____

_____

to release health care information of the patient names above to:

Metro Dermatology of NY, PC / Metro Dermatology of NJ, PA

- 144-72 Northern Blvd Suite 203, Flushing, NY 11354
- 220 East 161st St, Bronx, NY 10451
- 40-12 80th St, Elmhurst, NY 11372
- 2175 Lemoine Ave 6th Floor, Fort Lee, NJ 07024

Please fax to: (718)961-0666 or (201)227-1789

This request and authorization applies to:

____ Health care information relating to the following treatment, condition or dates of treatment:

____ All health care information Other: _____

This authorization is valid for **14 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. 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.

/ /

Signature of patient or patient's authorized representative Date Signed

_____

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

/ /

Office staff print/ signature Date Signed