DERMATOLOGISTS of BIRMINGHAM

Authorization for Release of Healthcare Information

Patient Name: _____ Date of Birth: _____

I hereby authorize Dermatologists of Birmingham to release the following:

- ☐ Entire contents of chart

  OR
- ☐ Progress notes
- ☐ Pathology reports
- ☐ Lab reports
- ☐ Correspondence
- ☐ Operative reports

TO: _____

_____

_____

I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including HIV, AIDS, and Sexually Transmitted Diseases.

THIS CONSENT EXPIRES 180 DAYS AFTER DATE OF SIGNATURE

_____ _____

Signature of patient Date Signature of Parent/Guardian Date

_____ _____

Witness Date Relationship to Patient Date