DERMATOLOGISTS
of BIRMINGHAM

Authorization for Release of Healthcare Information

Patient Name: _____ Date of Birth: _____

I hereby authorize the transfer of the following healthcare information:

FROM: _____

_____

_____

TO:

Dermatologists of Birmingham – 280 3570 Grandview Parkway, Suite 100B Birmingham, AL 35243 Tel: 205.588.7000 Fax: 205.621.9507	**Dermatologists of Birmingham – Alabaster** 1022 First Street North, Suite 201 Alabaster, AL 35007 Tel: 205.621.9500 Fax: 205.621.9507

- ☐ Entire contents of chart

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

Purpose of Disclosure:

- ☐ Continuing Patient Care
- ☐ Other

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