ROBINSON & MAX DERMATOLOGY, P.A.
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Authorization for Release of Medical Records

NAME OF PATIENT: _____

DATE OF BIRTH:_____

I hereby authorize ROBINSON & MAX DERMATOLOGY to release a copy of my medical records to be used for my continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDs, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

PLEASE RELEASE THIS INFORMATION TO:

_____

_____

_____ _____
Patient or Guardian Signature Date

Please include the following items:

_____Admission
____ Discharge Summary
____ Operative Reports
____ EKG'S
____ X-Rays
___ Progress Notes
___ Pathology Reports
___ Consultation Notes
___ Laboratory Tests
___ Registration

REMARKS: _____

This authorization will expire on _____.