

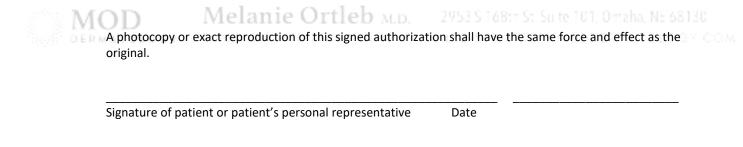
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Authorization for Release of Health Information

Patient Name	D.O.B.
Address	
Phone #	
l hereby authorizefollows:	to disclose my health information as
() Check here if disclosure is at	the request of the individual
Disclose () To () Fr	rom (Please check one)
Name:	
Address:	
City, State and Zip	
Information to be disclosed: (check all that apply)	
() History and Physical Exam () Consultation Rep	ort
() Progress Notes () Lab Reports	
() Imaging Reports () Complete Record	
Dates of service or time period of records to be disclose	
(sta	te time period or "all")

I understand and acknowledge that:

- 1. My refusal to sign this authorization will not affect my ability to obtain treatment at MOD Dermatology, PC.
- 2. Medical information to be disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by State or federal law.
- 3. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to MOD Dermatology. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
- 4. I have read (or had read to me) and have received a copy of this document.



Relationship to patient if signed by personal representative