

Brentwood Dermatology

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Lilly Zhu, MD

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Authorization to Release Medical Records/Information

Physician to provide records: _____

Patient Name: _____

Social Security # _____ Date of Birth: _____

Person/Facility to receive records

Address: _____ Phone/Fax: _____

Release these records:

Initials

- 1. Only records generated by this facility (not including records received from other sources) _____
- 2. Only some portion of records maintained at facility (dates of treatments, etc. Specify Below) _____
- 3. ALL medical records at this facility _____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOU MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Please Initial:

_____ Substance abuse, if any _____ AIDS/HIV, if any _____ Psychological or psychiatric conditions, if any

Other (Please Specify) _____

Expiration or revocation of authorization- I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Use of copies- A copy of this authorization may be utilized with the same effectiveness as an original

Patient name: (PRINT)

Person authorized to sign for patient: (PRINT)

Signature:

Signature & Relationship to patient:

Date: _____