

**Knott Street Dermatology, PC**  
**Authorization for Release of Information**

Patient Name	Date of Birth	Social Security Number	
_____	_____	_____	
Street Address	City	State	Zip
_____	_____	_____	_____
Daytime Phone	Evening Phone	Email Address	
_____	_____	_____	

I authorize you to **OBTAIN** health care information **FROM**:

Name \_\_\_\_\_

Title/Organization \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

I authorize you to **SEND/DISCLOSE** health care information **TO**:

Name \_\_\_\_\_

Title/Organization \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

- Patient to Pick up       Please fax to \_\_\_\_\_       Please Send

Please disclose the following information:

- All dermatology progress notes and correspondence for the past 3 years
- All skin pathology reports
- All laboratory reports generated for dermatology over the preceding 3 months

I understand that my records may contain information pertaining to psychiatric conditions, sexually transmitted diseases, HIV, HIV-related illnesses, AIDS, drug and alcohol abuse. I give my specific authorization for these records to be released UNLESS I have initialed the lines below.

_____ HIV, HIV-related illness, AIDS, AIDS-related illness	_____ Sexually transmitted diseases
_____ Psychiatric disorders/mental health treatment	_____ Drug and/or alcohol use

**Reason for disclosure:**

- Referral or second opinion       Transfer of care

This authorization ends 90 days after the date it is signed and may not permit disclosure of health information created more than 90 days after the date signed.

I understand that I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization by writing a letter to Knott Street Dermatology, PC. If I did, it would not affect any actions already taken by Knott Street Dermatology, PC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once health care information is disclosed, the person or the organization that receives it may re-disclose it.

\_\_\_\_\_  
Patient or legally authorized representative signature      \_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (if not signed by patient)      \_\_\_\_\_  
Printed Name if signed on behalf of patient