Franklin Dermatology Group

740 Cool Springs Blvd, Suite 200
Franklin, TN 37067
615-771-1881 (Telephone) 615-771-0050 (fax)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PRINT CLEARLY

Patient Name: _____Date of Birth: _____

I hereby authorize the following physician, employees and agents to release or disclose to the below-named recipient all of my medical records for the purposes listed elsewhere on this page.

I hereby authorize the release of my medical records FROM:

_____ _____ _____
(Name) **(Contact Number)** **(Fax Number)**

_____
(Street Address – City/State)

Please send my medical records TO:

_____ _____ _____
(Name) **(Contact Number)** **(Fax Number)**

_____
(Street Address – City/State)

Purpose of disclosure: _____

The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition or date(s) of treatment:
_____

_____ Specific records to be released (eg. Labs, imaging reports, other):
_____

If you DO NOT WANT certain portions of your medical records released, please initial the line for the information you <u>do not</u> want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____
Signature of Patient or Authorized Representative Date Signed

_____
Relationship to Patient