Aesthetic Dermatology & Cosmetic Surgery Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM

Patient Name: _____ _____ _____
(Last) (First) (Initial)

Date of Birth: _____ Acct or MR#: _____

I AUTHORIZE:

Aesthetic Dermatology (ADCS)

OR: (where your medical records currently are)

TO RELEASE/DISCLOSE HEALTH INFORMATION TO:

Aesthetic Dermatology
□ 535 Miller Ave., Mill Valley, CA 94941
□ 22 Battery St. #905, San Francisco, CA 94111

OR: (where you want your ADCS records sent)

PURPOSE FOR THIS REQUEST (check one):
□ Transfer of care □ Insurance coverage
□ Personal □ Other (please describe)

TYPE OF RECORDS REQUESTED (check one)
□ Specific information as noted (check one or more)
□ Laboratory Reports □ Pathology Reports
□ Operative Reports □ Photos □ Other
□ Copy of entire record, as allowed by law

AUTHORIZATION VALID FOR (check one):
□ This request only □ One year from the date of this request OR until _____

I understand that:

My right to healthcare is not conditioned on this authorization. If these records are needed for my enrollment in a Study, my refusal to sign this could result in my not being part of that Study. I may cancel this authorization at any time by submitting a WRITTEN request to ADCS , except when a disclosure has already been made in reliance on my prior authorization. If the person receiving this information is not a healthcare or medical provider covered by privacy regulations, the information stated above could be re-disclosed. Release of HIV related information, mental health related care, or substance abuse diagnosis and treatment requires additional authorization. There may be a charge for the requested records.

Patient's (or representative's) Signature: _____ Date: _____

Relationship if not patient: _____