CULLMAN DERMATOLOGY CLINIC, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ________________________________ DOB: ____/____/_________

( ) I DO NOT wish to have test results or other information released to any person other than myself.

( ) I DO wish to have test results or other information released to the following person (s).

Name ________________________________ Relationship _________________________

Phone Number ____

Name ________________________________ Relationship _________________________

Phone Number ____

Name ________________________________ Relationship _________________________

Phone Number ____

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Information with Cullman Dermatology Clinic, P.C.

Please understand that it may be necessary for us to disclose some or all of the information contained in your medical records to other physicians, nurses, and/or healthcare providers (collectively referred to as “providers”). Occasionally, other providers assist us in assessing a patient’s condition, screening for potential problems, or providing consultation under certain circumstances. You can be assured that those professional healthcare providers will maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measures, it may be necessary to disclose information to your healthcare agencies (both private and governmental), your insurance company and/or your self-insured employers. Regarding the information going to your employer, other than information to verify your insurance coverage, the data released will consist of statistical information only. Unless revoked, this authorization will expire 2 years from today’s date.

Patient (or Guardian, if Minor) Signature ______________________________ Date _____/_____/___________

Internal Office Use – Please do not complete below this line

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Witness ____ Exp. Date _____/_____/________