SK DERMATOLOGY
COSMETIC & MEDICAL SKIN CARE

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE SK DERMATOLOGY TO RELEASE MY MEDICAL RECORDS TO:

_____PHYSICIAN _____INSURANCE CO. _____LEGAL _____HOSPITAL _____OTHER

NAME:_____

ADRESS:_____

PHONE:_____FAX:_____

EMAIL:_____

INFORMATION, ACCESS TO, OR PHOTOCOPIES OF THE MEDICAL RECORDS OF:

PATIENT NAME:_____

DATE OF BIRTH_____

ADRESS:_____

PHONE:_____FAX_____

EMAIL_____

THE FOREGOING IS CONFINED TO THE LIMITATIONS AS LISTED BELOW:

1. Nature of information to be released: _____

2. Specific dates of treatment:_____

3. Pathology reports only _____

4. Purpose of request: _____

It is my intent that information furnished is prohibited for any purpose other than that stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.
I further direct that only information prior to the date of my signature below be honored, and that a photocopy of this authorization be granted the same authority as the original.
I further release Dr. Sylvie Khorenian and the staff of SK Dermatology from all legal responsibility and/or liability that may arise from the release of such records as specified above, and I hereby waive all rights I have to preserve their confidentiality.

_____ _____
Patient Signature Date