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Advanced Skin & Laser Center (ASLC)
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____Date of Birth: _____

I hereby authorize Advanced Skin & Laser Center and its physician(s), employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

List below the name of the physician or office where the records are to be released. List your name if the records are to be released to you, the patient.

Name_____

Address_____

Phone Number_____ Fax Number_____

Purpose of disclosure: _____

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

This request and authorization applies to:

_____Health care information relating to the following treatment, condition, or dates of treatment: _____

_____Specific records to be released (eg. Labs, Pathology, Visit Notes):_____

_____All medical records

If you DO NOT WANT certain portions of your medical records released, please initial below for the information you do not 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.

Prepaid fees: flat fee of $20 for copying medical records, plus the cost of postage and/or electronic media. TN Code/Title 63 Professions Of The Healing Arts/Chapter 2 Medical Records/63-2-102.

Patient or Authorized Representative's Signature: _____

Date: _____ Relationship to Patient_____