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Board Certified Dermatologists
Members of The American Society
for Laser Medicine and Surgery

DERMATOLOGIC
LASER CENTER

AUTHORIZATION REQUEST FORM

You may give the Dermatologic Laser Center written authorization to disclose your protected health information (PHI) and the contents of your medical record to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive this information, please complete the form below.

Patient Information: (Please Print)

Last Name First Name Middle Initial

Date of Birth SS#

At my request, I authorize the Dermatologic Laser Center to disclose my protected health information and/or the contents of my medical records to:

Name: (Print Name) Relationship:

*Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your medical information: (1) your date of birth, and (2) your social security number.

The disclosed information should include the following:

___Complete medical records ___Clinic Notes/Office Visits ___Billing Information

___Lab Reports ___Consultations ___Other_____________________

I would like this authorization to expire on ___/____/____.
(If no expiration date is provided, this authorization will expire twelve months from the date of receipt.)

I understand I may revoke this authorization at any time by giving the Dermatologic Laser Center written notice. However, if I revoke this authorization, I also understand that the revocation will not

affect any action the Dermatologic Laser Center took in reliance on this authorization before the Dermatologic Laser Center received any written notice of revocation.

Patient Signature: Date: