GARDENS DERMATOLOGY
& COSMETIC SURGERY CENTER

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Gardens Dermatology
to release healthcare information of the patient named above to:

Name: _____

Address: _____

City, ST, Zip: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

List:

☐ Complete medical record

☐ Other:_____

Signature:_____ Date:_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

By signing above, I authorize the above named physician(s) or any staff to disclose, reveal, or open for inspection or observation, any report, statement, analysis, diagnosis or any record including mental, psychiatric, alcohol and drug abuse, and HIV records. I hereby release the above named physician(s) and staff from any restrictions imposed by law, in disclosing or revealing any professional record, observation or communication to the person(s) named.

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