Atlanta Skin Cancer Specialists, PC

Authorization for Release Of Medical Records

Date Of Request:_____/_____/_____

Patient's Name_____Date Of Birth:____/____/____

Address:_____City:_____State/Zip:_____

Patient's Social Security Number : (REQUIRED For All Requests): _____/_____/_____

Patient's Contact Number:_____

☐ I authorize Atlanta Skin Cancer Specialists to release my information to:	☐ I authorize Atlanta Skin Cancer Specialists to obtain my information from:
_____ Name of Provider/Facility	_____ Name of Provider/Facility
_____ Address	_____ Address
_____ City, State and Zip Code	_____ City, State and Zip Code
_____ Office Number and or Fax Number	_____ Office Number and or Fax Number

Information To Be Released: (Check all applicable categories)

- ☐ Complete Copy Of All Records
- ☐ Telephone/verbal Communications
- ☐ Lab/Pathology Reports
- ☐ Itemized Invoices/Bills
- ☐ Counseling & Consultation Notes
- ☐ Other:_____

Purpose Or Need For Disclosure: (Check all applicable categories)

- ☐ For Further Medical Care
- ☐ Application For Insurance Policy
- ☐ Disability
- ☐ For Payment Of Insurance Claims
- ☐ Legal Investigation
- ☐ Other:_____

Patient Disclaimer- I understand that:

- **My right to healthcare treatment is not conditioned on this authorization.**
- **I may cancel this authorization at any time by submitting a *written* request to this office, except where a disclosure has already been made in reliance on my prior authorization.**
- **If the person or facility receiving this information is not a health care or medical provider covered by privacy regulations, the information stated above could be redisclosed.**
- **There may be a charge for this records request.**
- **I have the right to inspect the medical information which I am authorizing, with certain exceptions provided under state and federal law.**

Signature Of Patient:_____Date: _____/_____/_____