SUTTON
DERMATOLOGY + AESTHETICS

Board Certified Dermatologists
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Release of Medical Information

FILL OUT highlighted areas

______________________________ ______________________________

Patient Name (Print) Patient DOB Medical Record Number (office use only)

1. _____I authorize Sutton Dermatology + Aesthetics to **RELEASE** my records/health information TO:

Name:____

Address:_______________________ City:_______________ State:_______ ZIP: __________

Phone ( )___________________ Fax ( )___________________

-OR-

2. ____I authorize Sutton Dermatology + Aesthetics to **RECEIVE** my records/health information FROM:

Name:_______________________________ Send by: ☐ Mail ☐ Fax ☐ Secure Mail

Address:_______________________ City:_______________ State:_______ ZIP: ________

Phone ( )___________________ Fax ( )___________________

Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

☐ Records from last ________years
☐ Pathology/Lab results. Dates_______________________________
☐ Other (please describe): ____ The

identified information will be used for the following purpose (Please check one):

☐ My personal records
☐ Sharing with other health care providers as needed
☐ Other (please describe): ____

Please initial each item below to indicate your understanding.

______ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

______ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

______ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

______ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

____ ______/ ______ /_________

Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other: ______________________

This Authorization expires one year from date signed.

Sender_______________________________________Date____________________