RADIANT
DERMATOLOGY & AESTHETICS

AUTHORIZATION TO RELEASE MEDICAL RECORD

Patient Name _____ **DOB:** _____

I authorize Radiant Dermatology & Aesthetics, PLLC to use or release medical record to:

_____

_____

_____

_____

Reason of release of medical record: _____

Please release the following:

___Entire Record

___Record from Date of Service _____ to _____

___Diagnostic / Testing Results with dates _____ to _____

I understand that 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.
___**Yes**, I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that 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. Unless otherwise revoked, this authorization **expires within 60 days** from the signature date.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Internal Use Only

Date requested: _____ # pages copied_____ Reviewed by_____

Charges $_____ Paid Date _____

Prepared by: _____ Date Completed: _____