Perri Dermatology, PLLC
Anthony J. Perri, M.D.
Board Certified Dermatologist

Authorization for Release of Medical Information

Patient's Name: ____ DOB:________________
Address:____
City/State/Zip Code: ____
SS#: ___________________________ Patient's Phone #: ______________________________________
Date of Request: _____________________________ Date Needed:______________________________

I authorize Perri Dermatology, PLLC to release information to:	I authorize Perri Dermatology, PLLC to obtain information from:
______________________________________ Name of Provider/ Facility	____ Name of Provider/ Facility
______________________________________ Address	____ Address
______________________________________ City, State, Zip Code	____ City, State, Zip Code
______________________________________ Phone #/ Fax # (Including Area Code)	____ Phone #/ Fax # (Including Area Code)

PURPOSE FOR THIS REQUEST: (Check One) Specialist Transfer Other: __________________

TYPE OF RECORDS REQUESTED: (Check one)

All medical records; or
I only want parts of my medical record, described below, to be disclosed:

____

AUTHORIZATION VALID FOR: (Check One)

This request only.
One year from date of this authorization Or _________(insert date). This authorization applies to the records of the treatment received on or prior to the date of the authorization.
This request and for medical records of any future treatment of the type described above until:________ (insert date).

I understand that:

- My right to healthcare treatment is not conditioned on this authorization. 45 CFR 164.508(c)(2)(iii)
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization. 45 CFR 164.508(c)(2)(iii)
- I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus(HIV) and Acquired Immune Deficiency Syndrome(AIDS). 45 CFR 164.508(c)(2)(iii)

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke this authorization in writing prior to that time.

____ ____________________________
Signature of Patient or Representative/Relationship to Patient Date