Certified
Dermatology

Phone:732-456-7777
NJDermDoc.com

Authorization for Release of Medical Record Information

Attention: Tina Whaley: Medical Records Fax: 732-876-5371

Patient Information		
Last Name	First Name	MI
Street Address		
Date of Birth: / /	Email:	
Phone: ( )	Fax: ( )	
Certified Dermatology has my permission to release information contained in the medical record of the above-named patient.		
Information requested (please be specific with dates if known):		
Restrictions/exclusions (if any):		
Purpose of release:		
Certified Dermatology will provide the information requested above to the following party (if applicable):		
Name	Attention	
Phone: ( )	Fax: ( )	
Street Address		

I hereby authorize Certified Dermatology to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded. I am aware that Certified Dermatology cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Certified Dermatology may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. Copy fees may be associated with this request for records. I can cancel this authorization in writing at any time, except to the extent that Certified Dermatology has relied upon it. For example, if I cancel it after Dedicated Dermatology has sent requested records, Certified Dermatology will not retrieve those records.

_____ _____

Signature of Patient / Authorized Representative Date

_____ _____

Printed Name Relationship to Patient*

* Patients over 18 years of age must sign their own release form. If this document is signed by a Power of Attorney (POA) please include evidence of your POA.