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Authorization for Release of Medical Information

Patient: ____ Date of Birth: ____________________
(Last) (First)

I authorize the use or disclosure of the above-named patient's protected health information as described below.

I hereby authorize ____ to release the information.
(Please provide the address or fax number of the receiving party other than Joy B. Chastain, M.D., P.C.)

Address: ____ Fax: ____________________

For the purpose of ____

Check Type of Record to be Released

☐ Complete Health Record (or check for certain sections)

☐ Hospital/ER Record
☐ History and Physical
☐ Discharge Summary
☐ Consultation Report
☐ Operative Reports
☐ Nursing Documentation
☐ Office Notes
☐ Most Recent Lab Work (BMP, CMP, Lipids, LFTs)
☐ EKG
☐ Chest X-Ray Report
☐ Patch Test Results
☐ Echocardiogram Results
☐ Nuclear Stress Test Results
☐ CT Scan Results
☐ Carotid-Vascular Study Results
☐ Medication Record
☐ Pathology Reports
☐ Other As Specified: ____

I understand that information in my health record my include information relating to Confidential Information an may include mental health, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Practice Manager. This would not apply to information that has already been released prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

____ ____________________
Signature of Patient / Parent / Guardian / Legal Representative Date

____ ____________________
Printed Name of Parent / Guardian / Legal Representative Relationship to Patient

Authority to Sign on Behalf of the Patient: ☐ Custodial Parent ☐ Durable Power of Attorney of Healthcare
☐ Other As Specified: ______________________________

Records may be faxed and/or mailed to the fax number and the address provided above.

Diplomate – American Board of Dermatology
Fellow American Academy of Dermatology and American Society of Dermatologic Surgery
American Society for Laser Medicine and Surgery