Z-ROC DERMATOLOGY
Medical, Aesthetic and Surgical Specialists

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Regarding

_____
(print patients name)

NOTE TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Any re-disclosure is strictly prohibited without the written permission of the patient/client/legal representative identified below.

I authorize _____ Phone(___)_____
(name of facility/person holding information)

_____
(Address)

_____
(City/State/Zip code)

to release written general medical information from my medical record as well as psychiatric/ psychological information, alcohol and/or drug abuse information, Human Immunodeficiency Virus (HIV) tests and other information pertaining to these tests or to treatment in connection with these test results to:

_____ Phone(____)_____
(Name of facility/person holding information)

_____ Fax(____)_____
(Address)

_____
(City/State/Zip code)

for the purpose of_____

Type of Request: All Medical Records_____Blood work_____Biopsy_____other_____

_____
Patients/Legal Representative's Signature Date Date of Birth