SOINE DERMATOLOGY
& AESTHETICS

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

□ All healthcare information (Including information pertaining to STDs, HIV/AIDS testing, whether negative or positive, and regarding drug, alcohol or mental health treatment

□ Healthcare information relating to the following treatment, condition, or dates:_____

_____

□ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.