DERMATOLOGY CONSULTANTS OF MARIN

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**Record Release Authorization**

I hereby authorize and request that

 release and disclose my health information and records to:

Doctor or Practice:

Address:

Phone: Fax:

This authorization applies to records matching the checked below:

 All Record Only Medical Records Only Cosmetic Records

 Biopsies and Results Labs

\*The receiver may use the medical information that is being released “At the request of the individual” unless otherwise stated.

 **Name:**

 **Date of Birth:**

 **Signature:**

 **Witness:**

 **Date of Request:**

\*This authorization will expire on:

* I know that I may revoke this authorization to the extent that it has not already been relied upon or by writing a statement that I withdraw my authorization for further release of records.
* Any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules: however, California law prohibits the receiver from making further disclosure of my health information unless the receiver obtains another authorization from me or unless such information disclosure is specifically required by law.
* I understand that authorizing the disclosure of this health information is voluntary and I do not need to sign this form to assure treatment unless the sole purpose of the treatment/examination/evaluation is to provide information to a third party.
* I have the right to receive a copy of this authorization