AUTHORIZATION TO RELEASE INFORMATION

Essex Dermatology, LLC | 20 Saybrook Rd. Essex, CT 06426 | (860) 767-9998 | Fax (860) 767-9161

I, _____ _____ authorize Essex Dermatology
Name **Date of birth**

☐ To **RELEASE** my medical records to: _____
Name of medical facility or designee

☐ To **OBTAIN** my medical records from: _____
Address

_____

Information to be released or obtained

☐ Entire record from (date) _____ to (date) _____

☐ Entire record (all dates past, present and future up to 180 days following the date of this release)

☐ Other _____

The information released will be used for the following purpose (any other use is prohibited)

☐ Transferring care ☐ Coordinating care ☐Other (please specify) _____

- I understand that records to be released may contain information pertaining to communicable/non-communicable disease including HIV/AIDS related information, psychiatric, drug and alcohol abuse treatment, and may also contain other confidential information.
- I understand that refusal to grant consent to release of information will not jeopardize the patient's right to obtain present or future treatment, except where disclosure is necessary for the treatment.
- I may revoke this authorization at any time by making a written request. My revocation will not apply to information already retained, used, or disclosed in response to this authorization form.
- This authorization will expire 180 days after the date appearing below or 180 days after the patient's final treatment; whichever is later.

_____ _____
Date Signature of patient or person granting authorization on behalf of patient

_____ _____
Date Signature of witness

If this form has not been signed by the patient, include signer's name, relation to the patient, and legal authority to sign:

_____