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# DERMATOLOGY Center of Atlanta

Medical, Surgical & Cosmetic Dermatology

9900 Medlock Bridge Rd.  
Johns Creek, GA 30097  
770.497.0699  
www.dermatology-atlanta.com

## PATIENT AUTHORIZATION FOR RELEASE OR REQUEST OF PROTECTED HEALTH INFORMATION

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- I authorize Dermatology Center of Atlanta to release certain protected health information about me to the party indicated below:

\_\_\_\_\_  
Physician/Third Party

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
Fax

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

- I authorize the following party to release certain protected health information about me to Dermatology Center of Atlanta, 9900 Medlock Bridge Road, Johns Creek, GA 30097. Fax 770.497.0388

\_\_\_\_\_  
Physician/Third Party

\_\_\_\_\_  
Address

### Authorized Information to Release:

- All of my medical records, including records obtained from other healthcare providers  
 Pathology and/or lab tests only  
 Other specifications: \_\_\_\_\_

By signing this release, I have authorized the above entity to disclose certain protected health information (PHI) about me to the indicated party. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. This authorization will expire upon completion or at such a time when I revoke it in writing.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
If applicable, Print Name of Legal Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

**NOTE: PLEASE PRINT & COMPLETE THIS FORM. YOU CAN BRING THE FORM WITH YOU TO YOUR VISIT OR FAX THE COMPLETED FORM TO OUR OFFICE AT 770.497.0388.**

**IF A PATIENT'S MEDICAL RECORD IS MORE THAN 15 PAGES, PLEASE DO NOT FAX. PLEASE MAIL TO:  
DERMATOLOGY CENTER OF ATLANTA, 9900 MEDLOCK BRIDGE RD, JOHNS CREEK, GA 30097**