LANE
DERMATOLOGY & DERMATOLOGIC SURGERY

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

PLEASE COMPLETE REGARDING **PATIENT:**

Name (Last, First, MI)		
Street Address		Telephone
City	State	Zip
Social Security Number	Date of Birth	

Records Released From:

Name (Healthcare Facility/Physician)		
Street Address		
City	State	Zip
Telephone #:	Fax #:	

Records Released To:

Name (Healthcare Facility/Physician) **LANE DERMATOLOGY & DERMATOLOGIC SURGERY**		
Street Address **1210 BROOKSTONE CENTRE PKWY**		
City **COLUMBUS,**	State **GA**	Zip **31904**
Telephone #: **706-322-1717**	Fax #: **706-322-1718**	

PLEASE **DO NOT** COMPLETE THIS SECTION

Information to be released: (Please check all applicable categories)

- ○ Complete copy of all records
- ○ Laboratory Reports
- ○ Allergy Records
- ○ X-ray Reports/Films
- ○ Telephone Records
- ○ Coding Itemization
- ○ Immunization Records
- ○ Counseling
- ○ Clinic records pertaining to the treatment of: (specify date(s) or condition(s):

_____

- ○ Other: (please specify) _____

Purpose or need for disclosure: (please check all that apply)

- ○ Further Medical Care
- ○ Insurance Application
- ○ Legal Investigation
- ○ Payment of Insurance Claim
- ○ Academics
- ○ School Disability
- ○ Personal
- ○ Other: _____

PLEASE **READ AND SIGN** THIS SECTION

I understand that this authorization will remain in effect until this request is processed unless otherwise specified in the information above. I further understand that my written consent is necessary to revoke this request.

I, the undersigned patient (parent or legal guardian if minor patient) authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material upon my request. A photocopy of this consent shall be valid as the original. All releases will be processed within 72 hours of receipt.

X_____ _____

Patient Signature (parent or legal guardian if minor) Date

Notice to recipient of information: This information has been disclosed to you from confidential medical records which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.