



SUMMIT

Plastic Surgery & Dermatology

Authorization for Release of Health Information

I _____
(Print full name) (Date of Birth)

hereby authorize the release of my health information.

From:

Name: _____

Address _____

Phone _____ Fax _____

To:

Name _____

Address _____

Phone _____ Fax _____

I understand and acknowledge this may include alcohol/drug abuse, mental health, or HIV/Aids information.

Purpose of disclosure:

Information requested:

I give my permission for the information listed above to be released to the above names requestor. I understand that I may invoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 90 days after the date signed. The requestor should not re-disclose my medical records to another party without further written consent.

Date: _____ Signed: _____

Witnessed by: _____