Patient Information:	Name: Day Phone:	Date of Birth: Email:
Health Care office that has the information you want released:	Name/Organization: Address:	Phone: Fax:
Where do you want the information sent?	Name/Organization: Address:	Phone: Fax:
Why are the records needed?	◯ Continuing Care ($22.88 flat rate) ◯ Personal Use/Record ($22.88 flat rate + $0.50 a page)	◯ Legal
What are the approximate dates of information you want released?	◯ Service dates between _____ and _____ OR ◯ Last 5 years	
What do you want released?	◯ Office notes ◯ Laboratory Reports	◯ Pathology Reports ◯ Routine (check this for routine items a health care provider typically needs if you are unsure
When are the records needed?	Date:	
How would you want the information:	◯ Fax to provider indicated	◯ I will pick up paper copies

· This authorization lasts for one year after the date you sign it unless you enter a different expiration date: _____
· I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
· I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
· I understand that Easton Dermatology Associates may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
· I understand, upon request, I will receive a copy of this form after I have signed it.
· I understand that a photocopy or fax of this form is the same as the original.

Patient Signature and Date:	Sign: Date:	Relationship to patient: ◯ Self ◯ Parent of minor ◯ Other authorized guardian/conservator (must include legal documentation)

Please bring this completed form to one of the Easton Dermatology Associates offices or fax to 410-822-0416.