

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
TO**

Brighton Dermatology & Cosmetic Surgery Center
2300 Genoa Business Park Dr., Suite #220 Brighton, Michigan 48114
Phone (810) 220-4422 Fax (810) 220-1123

Patient Legal Name: _____

Previous/Maiden Name: _____ Date of Birth: _____

Street Address: _____

City/State: _____ Zip: _____

Phone Number(s): _____

Authorizes:

Physician Name: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

To Release the Following:

_____ Pathology Report _____ Lab Report _____ Summary of Care

_____ Other: _____

In compliance with state statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

_____ Behavioral Health Care/Psychiatric Care _____ Alcohol and/or Drug Abuse Treatment

_____ AIDS/HIV and/or other Communicable Diseases _____ Other _____

To Brighton Dermatology & Cosmetic Surgery Center (see address/fax above)

Purpose for Need of Disclosure (check applicable categories):

_____ Further Medical Care _____ Legal Investigation or Action _____ Personal

_____ Worker's Compensation _____ Insurance Eligibility/Benefits _____ Changing Physicians

_____ Other _____

This authorization may be revoked at any time, except to the extent that Brighton Dermatology & Cosmetic Surgery Center has already taken action in reliance upon it. I must present my revocation in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the privacy rule. If not previously revoked, this authorization will expire six (6) months from the date of signature. Photocopies of this authorization are considered as valid as the original.

Patient Signature: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

Relationship to Patient: _____ Witness: _____ Date: _____