MEDICAL RECORDS RELEASE

Name _____

Date of Birth _____ S.S.# _____

Address _____

City, State, Zip _____

Cell _____ Home _____ Email _____

I hereby authorize Chelsea Skin & Laser to release information from my medical record sent to:
(If self, please indicate below):

Name _____

Address _____

City, State, Zip _____

Phone: _____ Fax: _____

Reason for the release of information _____

Describe information to be released _____

Covering records from (Date) _____ to (Date) _____

CONFIDENTIAL INFORMATION
I understand that if my record contains information concerning mental health and/or drug and alcohol treatment such information will be released pursuant to this authorization.

I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

I consent to disclosure of:

___ My HIV-related information as detailed above
___ My non-HIV medical information as detailed above
___ Both (non-HIV medical and HIV-related information) as detailed above

This authorization will automatically expire within six months from the date of signature. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Chelsea Skin & Laser. I understand that the revocation will not apply to information that has already been released in response to this authorization.

By signing this form I consent to the release of my medical information and/or HIV-related information to the person/people listed above.

I also understand that in order to process this request to reproduce information, there may be a reasonable administration fee and/or photocopy service fee for records in excess of 10 pages. According to NY State law, a fee of $.75 per page plus postage if mailed may be charged. If you have 3 visits or more at our location, it is likely your chart is more than 10 pages. Kindly include your credit card information below if you'd like to expedite this request. No charge will exceed $25.00.

Please allow 7-10 business days for processing.

My signature authorizes the release of information to photocopy service, if necessary, for the purpose of satisfying this request and approves payment of reasonable fees by the credit card information below.

_____	_____	_____	_____
Name on Card	Credit Card Number	Expiration Date	CSV Code

_____ _____
Signature of Patient / Legal Representative PRINT and SIGN — Date

CHELSEA SKIN & LASER

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