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40-12 80th St ,Elmhurst , NY 11373 (718)886-9000 Fax: (718)961-0666

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone # \_\_\_\_\_

I request and authorize from :

Metro Dermatology of NY,PC / Metro Dermatology of NJ,PA

- 41-61 Kissena Blvd Suite 5A,Concourse Level , Flushing NY 11355
220 East 161st St, Bronx NY 10451
500 Grand Avenue Suite 201, Englewood NJ 07631
40-12 80th St., Elmhurst NY 11372

to release health care information of the patient named above to:

(NEW Doctor - please include address and phone number)

This request and authorization applies to:

\_\_\_\_\_ Health care information relating to the following treatment, condition or dates of treatment:

All health care information Other: \_\_\_\_\_

This authorization is valid for 14 days from the date of signature and there will be fees to process it.
The patient can revoke this authorization at any time by notifying the practice in writing. This would
not affect any actions already taken by the practice based upon this authorization.

I understand that I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment or eligibility). However, I do have
to sign it to receive health care when the purpose is to create health information for a third party or take part in research study.

Once health care information is disclosed, the person or organization that receives it may re-disclose it and our practice will not be responsible for this release. The
Privacy laws may no longer protect it.

I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL,
DRUG, AND PSYCHIATRIC TREATMENT, AIDS AND/OR HIV TESTINGAND/OR OTHER SEXUALLY TRANSMITTED DISEASES. I UNDERSTAND THIS INFORMATION WILL BE
RELEASEDUNLESS I SPECIFICALLY REQUEST THAT IT BE WITHHELD.

Signature of patient or patient's authorized representative

Date signed

Relationship if signed by anyone other than patient (parent, legal guardian, etc.)

Office Staff Signature

Date released