DERMATOLOGY **A**SSOCIATES of **C**ONCORD, Inc

Terry P. Hadley, M.D. | Eileen M. Deignan, M.D. | Kathryn E. Bowers, M.D.
Caroline L. Levine, M.D. | Alexis C. Perkins, M.D. | Matthew T. Zipoli, M.D.
Christina N. Alavian, M.D. | Cheryl A. Gray, M.D. | Lauren Alberta-Wszolek, M.D.
Julie A. Fenner, M.D. | Anne E. Allan, M.D. | Vadim A. Villarroel, M.D.

290 Baker Ave Concord, MA 01742 |625 Mount Auburn St Cambridge, MA 02138 |355 Waverley Oaks Rd Waltham, MA 02452

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS*

Patient Name: ____ Date of Birth: _________________

Address: ____

____

Phone: ____

I hereby authorize the use and disclosure of my medical records as specified below. I understand that my records may contain information regarding diagnosis and/or treatment of sensitive conditions such as HIV/AIDS, sexually transmitted diseases, drug and alcohol use/abuse, mental illness, developmental disabilities, and genetic information, unless excluded here____

Information to be disclosed:

Pathology/Lab reports____________ Surgical notes___________ Progress Notes_____________

Other____

All records*_________

Treatment dates: From: ____________________________To:_________________________________

Purpose of release/disclosure to other person/organization (circle one):

Continuity of Care/Transfer of Care Attorney/Legal Insurance Company

Other (specify) ____________________

*Unless otherwise specified, and if applicable, cosmetic services notes will be included.

Release From: Dermatology Associates of Concord, Inc.

Concord Fax#: 978-371-9675
290 Baker Avenue Extension Concord, MA 01752

Cambridge Fax#: 617-354-9135
625 Mount Auburn Street Cambridge, MA 02138

Release To: ____

____

Office #: ________________________________ Fax#: _____________________________________

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This authorization is intended for the release of information only to the party specified.

Expiration Date of Authorization: This authorization expires on :________________(specify expiration date or event).

If the expiration date is left blank, the authorization expires one year from the signature date.

Right to Terminate or Revoke Authorization: You may terminate or revoke this authorization, except to the extent that Dermatology Associates of Concord has already disclosed your medical information in reliance of this authorization, by submitting a written revocation to the Dermatology Associates of Concord's Medical Record Representative.

Note: You may refuse to sign this authorization without affecting your ability to obtain treatment at Dermatology Associates of Concord. Information that is used or disclosed under this authorization cannot be protected from further disclosure.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. A copy of this authorization will be considered as valid as the original.

(SIGNATURE OF PATIENT OR LEGAL GUARDIAN/REPRESENTATIVE) DATE

If signed by a Legal Guardian/Representative, please complete the following:

1. **Name:____**
2. **The individual is a Minor______ Legally incompetent or incapacitated______ Deceased______**
3. **Legal authority: Parent**_______ Legal Guardian________ Activated POA for Health Care______ Next of kin/Executor of deceased_______**

****By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.**

For DAC use only:

Date request received: _______________ Signature reviewed:_______________ Date records released:_______________

Name and signature of DAC employee who released records:

____