Authorization for Release of Medical Information

I, _____, authorize Elite SkinMD to speak to the following person(s) regarding my test results and medical care.

Name: _____

Phone Number: _____

Relationship to Patient: _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the bottom of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by my privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information require additional authorization.

Signature of Patient or Representative: _____ Date: _____