Sairah Khokher, MD, FAAD Board
Certified Dermatologist

K DERMATOLOGY
& AESTHETIC CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH _____

I, _____HEREBY AUTHORIZE THE

RELEASE OF PATIENT'S MEDICAL RECORDS TO:

DOCTOR/ CLINIC: _____

ADDRESS: _____

FAX NUMBER: _____ PHONE: _____

Please release the following:

___ History / Physical Exam
___ Progress Notes
___ Biopsy/ pathology results
___ Laboratory results
___ Clinical Images

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

___ Yes, I consent to the release of this information
___ No, I do not consent to the release of this information

PURPORSE OF DISCLOSURE:

___ Treatment/ Continuing Medical Care
___ Change of Physician
___ Personal Use
___ Attorney/ Legal
___ Change of insurance
___ Others _____

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signed this day: _____

_____
Patient/ Parent / Guardian of Patient