1180 Resurgence Drive.
Suite 100
Watkinsville, GA 30677

GEORGIA SKIN CANCER
& Aesthetic Dermatology

Obtaining from:
Please **mail** records
larger than 20 pages.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE GEORGIA SKIN CANCER TO: *INITIAL BELOW*

_____ **RELEASE INFORMATION TO**:	_____ **OBTAIN INFORMATION FROM**:

_____
Entity or Name of Provider or Facility

_____
Address/City/State/Zip

_____
Phone Number Fax Number

Please *initial* specific information requested for release:

_____ Biopsy Results and Lab Reports - Specify if needed: _____

_____ Dermatologic Surgical Procedures – Specify if billing-related: _____

_____ Medications/Prescription Plans

_____ Progress/Office Notes - Specify if needed: _____

_____ All Protected Health Information (PHI) in medical record

_____ Other _____

For the purpose of: CHECK ONE

___ Healthcare Facility/Continuing Care
___ Legal
___ Personal
___ Disability
___ Insurance/Cancer Policy
___ Transferring Care
___ Physician
___ Other (Please specify): _____

I understand I may revoke this authorization at any time in writing and present my written revocation to the Georgia Skin Cancer facility. Unless otherwise revoked, this authorization will expire one year from the date below signed or as listed: ____ / ____ / _____ .

_____ _____
Patient Name (Print) Date

_____ INTERNAL USE: MRN: _____
Patient Signature