Authorization to Release Health Information to Others

Patient Full Name (if name is changed, please specify)	Date of Birth
Street Address	City/State/Zip Code
Cell Phone	Home Phone

At my request, Noor Dermatology and Aesthetics, PLLC may release the following information to the recipient designated below:

☐ Entire Medical Record ☐ Financial Records ☐ Office Visit Notes ☐ Pathology Results Only
☐ Blood Test Results Only ☐ Other_____ Time Period To:_____From:_____

The Purpose of this disclosure is:

☐ Change of Insurance or Physician ☐ Continuation of Care ☐ Referral ☐ Personal Records
☐ Disability Determination ☐ Legal Investigation

Entity or Person who will receive the information:

Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

☐ Fax the requested information to the entity above. ☐ Will pick up at the practice
☐ Mail the requested information to the entity above.
☐ Send the requested information electronically. Email Address:_____
☐ By checking this box, I acknowledge that I understand that email communication is not sent in an encrypted format and there is a risk that it could be accessed inappropriately.

Restrictions: *Only medical records originated through Noor Dermatology & Aesthetics will be copied and disclosed unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date of this authorization unless otherwise specified. I may inspect or copy the protected health information to be disclosed as described in this document. Revocation must be done in writing and is not effective on information that has already been released. I may refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand released info;rmation may include communicable disease or behavioral or mental health information. Unless other noted, this authorization will expire within one year from the date of my signature.*

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Printed name of Parent/Guardian:_____ Relationship to Patient:_____