Authorization for Release and Examination of Medical Records

I, ________________________________, hereby authorize and request the release of [ ] Complete Medical Records, [ ] Biopsy Report(s), [ ] Lab Report(s), or [ ] other please specify ____:

Release from [ ] *Release to* { }

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Phone # ________________________

Fax # __________________________

Release to [ ] *Release from* { }

Advanced Dermatology, Inc.

Dr. Monique S. Cohn

8940 Darrow Road
Twinsburg, Ohio 44087-2110
Phone 330-425-7600
Fax 330-963-7900
Email: ***Dr.Cohn@YourGreatSkin.com***

If releasing to Advanced Dermatology, Inc., please furnish a complete copy of medical records and medical information including all diagnoses, all biopsy reports and all records of any treatment or examination rendered to:

Patient's Name ____

Address____

City, State, Zip____

Date of Birth__________________ Social Security # ______________________

during the period from ______________________ to ______________________

I authorize Dr. Monique S. Cohn and Advanced Dermatology, Inc. to allow the medical records and other medical information to be copied or examined by other parties including, but not limited to, my insurance company and/or other third party payors, billing agents, attorneys and other agents of Dr. Cohn and Advanced Dermatology, Inc.. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis. In executing this authorization, I hereby release all parties to this document from all legal responsibility or liability relating to the release, disclosure and examination of confidential medical information. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules. Dr. Cohn and Advanced Dermatology, Inc. will not condition treatment on the execution of this authorization. You have the right to revoke this authorization at any time by notifing Advanced Dermatology, Inc. in writing at the above address. Revocation of this authorization will not effect actions already taken in reliance on the authorization. If not revoked sooner, this authorization will expire 60 days after executed.

____ ________________________

Signature of patient or gardian Date

____ ________________________

Witness Date