METRO DERMATOLOGY

500 Grand Ave., Suite 201, Englewood, NJ 07631 (201)886-9000 Fax: (201)227-1789
41-61 Kissena Blvd., Suite 5A, Flushing, NY 11355 (718)886-9000 Fax: (718)961-0666
220 East 161st Street, Bronx, NY 10451 (718)292-9197 Fax: (718) 292-4429
40-12 80th St,Elmhurst , NY 11373 (718)886-9000 Fax: (718)961-0666

AUTHORIZATION TO REQUEST MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone _____
I request and authorize (*previous Doctor - please include address and phone number*)
_____

_____

to release health care information of the patient named above to:

Metro Dermatology of NY,PC / Metro Dermatology of NJ,PA

( ) 41-61 Kissena Blvd Suite 5A,Concourse Level, Flushing NY 11355
( ) 220 East 161st St, Bronx NY 10451
( ) 40-12 80th St., Elmhurst NY 11372
( ) 500 Grand Avenue Suite 201, Englewood NJ 07631

Please fax to: (718)961-0666 or (201)227-1789

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition or dates of treatment:

_____All health care information Other: _____

This authorization is valid for **14 days** from the date of signature and there will be fees to process it.
The patient can revoke this authorization at any time by notifying the practice in writing. This would not affect any actions already taken by the practice based upon this authorization.
I understand that I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment or eligibility). However, I do have to sign it to receive health care when the purpose is to create health information for a third party or take part in research study. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Our practice will not be responsible for this release. The Privacy laws may no longer protect it.
I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL, DRUG, AND PSYCHIATRIC TREATMENT, AIDS AND/OR HIV TESTINGAND/OR OTHER SEXUALLY TRANSMITTED DISEASES. I UNDERSTAND THIS INFORMATION WILL BE RELEASEDUNLESS I SPECIFICALLY REQUEST THAT IT BE WITHHELD.

_____

Signature of patient or patient's authorized representative Date Signed

_____

Relationship if signed by anyone other than patient (parent, legal guardian, etc.)

Office Staff Print/ Signature Date released