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DERMATOLOGY - ADULTS AND CHILDREN
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HIPAA “Health Insurance Portability and Accountability Act” was enacted to ensure the privacy and confidential handling of medical information for all patients.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DATE: _____

I _____, authorize the release of my medical records from Port Jefferson Dermatology to the following individual(s) and/or medical offices.

_____
_____
_____
_____

By signing this consent, I understand that the above listed individual(s) may call and speak with the office on my behalf regarding my medical information and request copies of my medical records.

Patient Signature _____