infinity
• dermatology •

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Authorization to Release Medical Information

The medical records of (patient):
Name: _____ Birthdate:_____
Address (street, city, state, zip): _____
Phone: _____

I give permission to Infinity Dermatology PLLC to (please check):

_____Release my records to: _____Obtain my records from:

Facility Name: _____
Address (street, city, state, zip):_____
Phone: _____
Fax:_____

The following information to be released (please check):
_____Entire Medical Record _____Pathology Results _____Lab Results
_____ER records _____Clinic Notes (Date Range:_____)
_____Surgical Notes _____Other:_____

I specifically authorize the release of any information I have INITIALED below:
_____HIV diagnosis/treatment _____Mental Health
_____Substance Abuse (alcohol and/or drug) diagnosis/treatment

Reason for Release (please check):
_____Continuation of care _____Transfer of care
_____Other: _____

This form does not expire from the date of signature. I understand that I may revoke this authorization at any time by sending a written notice to Infinity Dermatology PLLC.

Signature of patient or legal guardian: _____
Relationship to patient: _____ Date: _____

Updated 8/2022