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AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION

PRINTED NAME OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

SOCIAL SECURITY NUMBER

I hereby authorize the release of all information contained in my medical records from:

METROPOLITAN DERMATOLOGIC SURGERY, P.C.

- and send information contained in my medical records by standard mail post to
- and send all information contained in my medical records by fax transmission to

NAME OF PHYSICIAN

NAME OF PRACTICE

OFFICE PHONE NUMBER

OFFICE FAX NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

I UNDERSTAND THAT THIS AUTHORIZATION INCLUDES THE RELEASE OF CONFIDENTIAL INFORMATION WHICH MAY INCLUDE HIV RECORDS, PSYCHIATRIC MENTAL ILLNESS, DRUG/ALCOHOL ABUSE, VENERAL DISEASE AND ANY OTHER STATUTORY PROTECTED DISEASES. I UNDERSTAND THIS CONSENT MAY BE REVOKED BY ME AT ANY TIME BY WRITTEN NOTICE UNLESS THE RECORDS HAVE ALREADY BEEN RELEASED. THIS AUTHORIZATION WILL EXPIRE NINETY (90) DAYS FROM THE DATE SIGNED.

SIGNATURE OF PATIENT/GUARDIAN

DATE

GUARDIAN'S RELATIONSHIP TO PATIENT

SIGNATURE OF WITNESS

CONFIDENTIALITY NOTICE

This transmittal is intended only for the use of the individual or entity to which it is addressed and *may or may not contain protected health information which is strictly confidential*. This information may only be used or disclosed in accordance with federal law which contains penalties for misuse. If you are not the intended recipient of this transmission, you may not otherwise use or disclose the information contained in this transmission. **If you received this transmission in error, please return the transmission to METROPOLITAN DERMATOLOGIC SURGERY at 404/257-9933 and delete or destroy the information. Thank you.**

