AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Patient: ____Date:______________

Address:____D.O.B.:______________

I hereby authorize the release of my Medical Information to the office of: Agape Dermatology
191 Bedford Street Fall River, MA 02720 Ph: 774-488-5888 Fax: 508-674-8880

To release the following information: ____

____

Releasing information from: ____

____

Signature of Patient/Guardian: __________________________________Date:______________

Witness Signature: ____Date:_______________

This consent does not pertain to the following sensitive information without my specific consent and signature in the space below.

Abortion	Sexual Assault	HIV Testing	Mental Health Visits
Infertility Studies	Venereal Diseases	Drug/Alcohol Abuse	

I hereby authorize the release of the following sensitive information:

____

Signature of Patient/Guardian: ________________________________ Date:________________

Witness Signature: ____Date:________________