Aglow Dermatology
Dr. Dina D. Strachan
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New York, New York 10016

Phone Number: 212-627-1004
Fax: 212-473-2309

Authorization to Release Medical Information

I authorize *Aglow Dermatology* to release the medical information or records specified to:

_____
Name

_____
Address

_____
Phone Fax

Patient Name:_____ DOB:_____

RECORDS AUTHORIZED TO BE RELEASED: DATE OF SERVICE:_____

__Admission History & Physical
__Admission Patient Information
__Consultation Notes
__Lab Reports
__Other (specify)

_____
Patient or Guardian (signature) Date

_____
Patient or Guardian (print)

_____
Relationship to Patient

This authorization will expire one year from the date of the signature above. I understand that I can revoke this authorization at any time by writing to the health care provider or to Aglow Dermatology, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires an Authorization to Release Medical Information in order for health care providers to release medical information or records. New requirements for authorizations became effective April 16, 2003.