Dyersburg Skin Clinic

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Dyersburg, TN 38024
Telephone: (731) 286-4300
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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth** _____-____-_____

Name of Person or organizations providing the information: _____

Name of Person or organizations receiving the information: _____

Medical Records to include: ☐ **office notes** ☐ **labs** ☐ **x-ray's** ☐ **other** _____

PLEASE READ AND INITIAL THE FOLLOWING:

I understand that my health care and the payments for my health care will not be affected if I do not sign this form. **Initials:** _____

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. **Initials:** _____

I understand that this authorization will expire on ____/____/____ (DD/MM/YYYY) **Initials:** _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. **Initials:** _____

_____ _____
Signature of patient or patient's representative **Date**

Printed Name of patient's representative: _____

Relationship to the patient: _____

Office Use Only

What is the purpose of the use or disclosure? _____

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? **Yes___ No___**