AESTHETIC DERMATOLOGY
cosmetic procedures | lasers | skin care

SHELBY DERMATOLOGY
medical | surgical | skin care

# Authorization for Release of Healthcare Information

Patient Name: _____ Date of Birth: _____

**I hereby authorize Aesthetic Dermatology | Shelby Dermatology to release**

- ☐ Entire contents of chart
  **OR**
- ☐ Progress notes
- ☐ Pathology reports
- ☐ Lab reports
- ☐ Correspondence
- ☐ Operative reports

**TO**:

Name: _____ Relation: _____

I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including HIV, AIDS, and Sexually Transmitted Diseases.

**THIS CONSENT EXPIRES 180 DAYS AFTER DATE OF SIGNATURE**

_____ _____

Signature of patient Date Signature of Parent/Guardian Date

_____ _____

Witness Date Relationship to Patient Date