The Derm Group
347 Mount Pleasant Avenue, Suite 205
West Orange, NJ 07052

Authorization for Release of Medical Records

I consent and authorize The Derm Group to disclose information from medical records relating to my treatment. I understand that this consent shall operate as a complete release of liability for the physician or facility named above and all it's employees for their release of information as specified below.

Please complete information, sign below, and fax it to (732) 818-0087 or mail it to The Derm Group c/o Healthcare Solutions, LLC, 40 Bey Lea Road, Suite A101, Toms River, NJ 08753, Attn: Medical Records.

Patient Name: _____ DOB: _____

Address: _____

_____

Phone: _____

If released to other than patient/guarantor request for medical records to be released to the following:

Name:_____

Address: _____

_____

Phone: _____ Fax: _____

Special Instructions: _____

Mailed: _____ Picked-up: _____ Faxed: _____

Unless otherwise revoked by me, this authorization is valid for three months from the date above. I have read and understand the terms of this authorization and I have had the opportunity to ask questions about the use and disclosure of health information. I hereby, knowingly and voluntarily authorize The Derm Group to disclose my health information to the entities above, and I accept responsibility for inappropriate disclosure as a result of the of the method of disclosure used.

_____ _____ _____

Patient/Guarantor Signature Date Witness Signature