HUDSON
DERMATOLOGY

Consent for Release of Information

____ ____________________
Name of patient Date of birth

I hereby authorize (name of physician)______________________________________
or his/her employees or agents to release the following information from the medical records of the patient named above:

☐ copy of entire record
☐ test results
☐ other

I authorize this confidential information to be released only to the following person, agency or organization:

☐ Hudson Dermatology, P.C.

969 Main Street	29 Fox Street, 4th Floor
Fishkill, NY 12524	Poughkeepsie, NY 12601
(845) 896-7730	(845) 473-2350
(845) 896-7758 fax	(845) 473-4305 fax

☐ Other (name, address, telephone)

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The purpose of this disclosure is:

☐ continued medical care
☐ to process insurance claims
☐ to complete insurance application
☐ other (please specify) ______________________________________

This authorization to release confidential medical information may be revoked by me in writing at any time, except to the extent that action has already been taken in reliance on it. It will be effective only long enough to fulfill the specific purpose for which it is given or for 60 days, whichever is sooner. No further confidential information will be released without the execution of an additional written statement of consent.

____ ____________________
Signature of patient (or parent, if minor) Date of consent