HUDSON DERMATOLOGY

Consent for Release of Medical Records

Name of patient _____ Date of birth _____

I hereby authorize Hudson Dermatology, P.C., or its employees or agents to release the following information from the medical records of the patient named above:

☐ copy of entire record ☐ test results only ☐ other _____

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

_____

_____

_____

The purpose of this disclosure is continued medical care.

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 _____

Please complete and sign this form. You may scan and email it to hello@hudsondermatology.com, fax it to (845) 473-4305, or mail it to:

Hudson Dermatology
Records Request
29 Fox Street, 4th Floor
Poughkeepsie, NY 12601