HUDSON DERMATOLOGY

Consent for Release of Information

Name of patient _____ Date of birth _____

RELEASE TO HUDSON DERMATOLOGY, P.C.

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:

HUDSON DERMATOLOGY, P.C.			
969 Main Street, Ste. D	Fishkill, NY 12524	845 896 7730	845 896 7758 fax
29 Fox Street, 4th Fl.	Poughkeepsie, NY 12601	845 473 2350	845 473 4305 fax
40 Hurley Ave., 3rd Fl.	Kingston, NY 12401	845 338 3200	845 338 3233 fax
98 Green St., Ste. 4	Hudson, NY 12534	518 412 3300	518 412 3222 fax
155 White Plains Rd., Ste. 109	Tarrytown, NY 10591	914 829 8200	914 829 8201 fax
336 U.S. Route 202, Ste. 2	Somers, NY 10589	914 617 8950	914 617 8960 fax
55 Quaker Ave., Suite 202	Cornwall, NY 12518	845 458 8188	845 458 8122 fax

RELEASE FROM HUDSON DERMATOLOGY, P.C.

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 ☐ 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 ☐ other _____
☐ to process insurance claims ☐ to complete insurance application

I may revoke this authorization to release confidential medical information 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 _____