

ADVANCED DERMATOLOGY ASSOCIATES, LTD.  
1259 S. CEDAR CREST BLVD., SUITE 100, ALLENTOWN, PA 18103-6206  
Telephone: (610) 437-4134 Fax: (610) 433-9690

**AUTHORIZATION FOR ADVANCED DERMATOLOGY ASSOCIATES, LTD. (ADA),  
TO RELEASE PATIENT INFORMATION/RECORDS**

**My signature below authorizes:**

- Advanced Dermatology Associates, LTD., 1259 S. Cedar Crest Blvd., Suite 100, Allentown, PA 18103-6206
- Advanced Dermatology Associates, LTD., 700 Schuylkill Manor Road, Suite 5, Pottsville, PA 17901-3861

**to release via:**     Fax         Mail         Patient pick-up\*

**the following medical information/records:**

- All records         Pathology reports         Photos
- Lab reports         Slides/Accession #: \_\_\_\_\_
- for dates of service from \_\_\_\_\_ to \_\_\_\_\_

**of the following patient:**

Name: \_\_\_\_\_ ADA Account #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN: xxxx-xx- \_\_\_\_\_  
Address: \_\_\_\_\_

**to the following party:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I give special authorization to release information regarding:**

- Psychiatric/Mental Health**
- Substance Abuse**
- HIV information**

This authorization is being given with the understanding that the party receiving the records (unless released for patient pick-up) will be informed in writing by Advanced Dermatology Associates, LTD., that state law protects the confidentiality of this information and prohibits any further disclosure of the information without my (the patient's) specific written consent or as otherwise permitted by law. The party receiving the records will be informed that a general authorization for the release of medical or other information is not sufficient for this purpose.

**I understand that I may revoke this authorization through written notification at any time and that the notification can have no effect on actions taken prior to its receipt by Advanced Dermatology Associates, LTD. Otherwise, this authorization shall remain in effect and valid for 1 year from date signed. Medical records shall be processed within 14 days of the date requested. There is a processing fee for all requested records.**

**\*I further understand that if I request release of any records via "patient pick-up" Advanced Dermatology Associates, LTD., assumes no responsibility for any further disclosure I may make of the records after I take possession of them.**

**I understand that Advanced Dermatology Associates, LTD., is subject to the rules and regulations of the Health Insurance Portability and Accountability Act (HIPAA) and follows stringent privacy standards.**

**Printed Name of Patient Representative/POA, if applicable:** \_\_\_\_\_

\_\_\_\_\_  
(signature of patient –or– patient representative/POA)

\_\_\_\_\_  
(date signed)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(date signed)