

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 | 40 Hurley Ave., Ste. 10 |
| Fishkill, NY 12524 | Poughkeepsie, NY 12601 | Kingston, NY 1240 |
| (845) 896-7730 | (845) 473-2350 | (845) 338-3200 |
| (845) 896-7758 fax | (845) 473-4305 fax | (845) 338-3233 |

Other

The purpose of this disclosure is:

- continued medical care
 to process insurance claims
 to complete insurance application
 other _____

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