

## Consent for Release of Information

Name of patient \_\_\_\_\_

I hereby authorize Dermatology and Allergy Associates of the Hudson Valley to release my medical records to:

Hudson Dermatology, P.C.  
29 Fox Street, 4th Floor  
Poughkeepsie, NY 12601  
(845) 473-2350  
(845) 473-4305 fax

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