Please allow 7-14 business days to process requests.

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**Please print with black ink.**

Patient Name:____________________________ Date of Birth:____________

Address:____________________ City:____________ State:_____ Zip:________

Phone Number:____________________ Social Security Number:____________________

## Information to be *Released From:*

Doctor/Clinic name: ____________________

Address: ____________________

City:____________ State:_____ Zip:________

Phone Number: ____________________

Fax Number:____________________

## Information to be *Released To:*

Name: ____________________

Address: ____________________

City:____________ State:_____ Zip:________

Phone Number: ____________________

Fax Number: ____________________

**Information to be released: (MUST CHECK ALL THAT APPLY)**

☐ Pathology Reports ☐ Office Visit Notes ☐ Billing information

☐ Lab Reports ☐ Other ____________________

All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by your signature here: ____________________

**Please indicate any restrictions: (Specify)** ____________________

**For the following dates of treatment or condition:** ____________________

**I am requesting this information to be released for the following purpose:** ☐ Continued Care

☐ Insurance ☐ Legal ☐ Personal Use ☐ Transferring Dermatology Care ☐ Other __________

May we ask why you are choosing to transfer your dermatology care? ____________________

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- I understand I may revoke this authorization in writing at any time to the address listed at the bottom of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lessor period of time as specified here:____________________. The expiration period noted here may not exceed one year only in certain situations specified by law.
- I understand that once information is released pursuant to this authorization, ***Advanced Dermatology Care*** can not prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- A copy of this authorization is as valid as the original bearing my signature.
- Except for research-related treatment, ***Advanced Dermatology Care*** will not condition treatment on my signing this authorization.
- I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.
- I understand it may take 7-14 busienss days to process requests.

____________________ ____________________ __________

Signature of Patient or Legal Guardian | Relationship to the Patient (Parent, guardian, health care power of attorney, etc.) | Date

________________________________________

(Please give the reason that someone other than the patient is signing)