FAMILY DERMATOLOGY of ALBEMARLE

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Authorization for Release of Information

Patient Information

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Please Select ONE:

❑ I authorize Family Dermatology of Albemarle to release information **TO:**

Name: _____

Address: _____

City: _____

State: _____ **Zip Code:** _____

Phone #: _____

Fax #: _____

❑ I authorize Family Dermatology of Albemarle to obtain information **FROM:**

Name: _____

Address: _____

City: _____

State: _____ **Zip Code:** _____

Phone #: _____

Fax #: _____

❑ I authorize Family Dermatology of Albemarle to email my information to **me** at the following email address:

_____

Information Requested:

❑ Office Visit Notes	Dates: _____	❑ Lab Reports	Dates: _____
❑ Pathology/Biopsy Reports	Dates: _____	❑ Entire Medical Record	Dates: _____

Reason(s) for Request:

❑ Changing physicians	❑ Consultation/Second Opinion	❑ Insurance
❑ Legal	❑ Worker's Compensation	❑ Other (must specify):
❑ School	❑ Continuing Medical Care	_____

I understand the following:

- This authorization will expire 1 year after I signed this form.
- I may revoke this authorization at any time by notifying the providing organization in writing. My notification will be effective on the day it is received except to the extent action has already been taken on the original request.
- The information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.
- The information used before this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations

X

Signature of patient/legal guardian/authorized person	Date	Witness	Date

Office Use Only: Date Completed: By: