Medical Records Release

Authorization for Use or Disclosure of Protected Health Information

Please complete the following information: **Please Print**

Patient Name: _____

Date of Birth: _____/_____/_____

Address: _____

_____

Phone: _____

I authorize the Physician/Medical Practice of Greenwood Dermatology Associates, PC to disclose/release the following information to the Physician listed below.

This authorization shall be in effect until one year from the date of execution at which time this authorization expires.

☑ All Medical Records and Reports for all dates of service

TO: Name/Address/Phone Number/ Fax Number of practice listed below to release my information

_____

_____

_____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

The information may be used/disclosed to ensure continuity of care and for health maintenance purposes.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's Personal representative) Date

(I.e. parent, guardian, power of attorney for healthcare, executor)

1/4/2010

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