Buckeye Dermatology, Inc

5720 Blazer Parkway
Dublin, Ohio 43017
Phone: 614-761-1151
Fax: 614-761-1313

1933 Ohio Drive
Grove City, Ohio 43123
Phone: 614-277-9530
Fax: 614-277-2227

AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

PRINTED PATIENT'S NAME: _____DATE OF BIRTH_____

Check Item needed	HEALTH/MEDICAL INFORMATION TO BE DISCLOSED/RELEASED	Date(s) of service or treatment
	Pathology Reports	
	Lab Results/Reports	
	Assessment/ History and Physical/Procedures/Progress Notes	
	Entire Record	
	Other (Please List)	

_____Release of medical records TO BUCKEYE DERMATOLOGY, INC

I authorize _____to release
NAME/ADDRESS/PHONE/FAX
and send my medical records as specified above to:

Buckeye Dermatology, Inc.
5720 Blazer Parkway
Dublin, OH 43017
Fax: 614-761-1313
Phone: 614-761-1151

_____Release of medical records FROM BUCKEYE DERMATOLOGY, INC
I authorize Buckeye Dermatology, Inc to release my medical records as specified above to:

_____

_____

_____

I understand and acknowledge that the information in my medical record may include information relating to sexually transmitted disease, including HIV/AIDs test results or diagnoses, treatment for behavioral or mental health services, and treatment for alcohol/ drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above. If patient requests records to be faxed to another facility or physicians office, patient is aware of confidentiality risks involved and releases Buckeye Dermatology of responsibility of the fax.

I understand that I have the right to revoke this authorization at any time by writing to Buckeye Dermatology. I understand that any revocation will not apply to information that has already been released in response to this authorization. I understand this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be based upon whether or not I sign this authorization.

According to Ohio Revised Code, there is a per page fee for records. This fee will depend on the number of copies requested and other reasons as specified in ORC 3701.741 at codes.ohio.gov/ORC.

After my health information is released, I understand my information may be re-disclosed by the recipient and may no longer be protected by law.

PATIENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____