AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Lower Highlands Dermatology/Dr. Catherine Carretero to release my information to the following physician/practice, _____(name/address/fax) for transfer of medical care.

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

I authorize the release of the following protected health information: My entire medical record from Lower Highlands Dermatology. Please note this may include notes detailing behavioral health care/psychiatric care, alcohol and/or drug abuse treatment, AIDS/HIV and other communicable disease information, unless specifically excluded.

Please exclude: _____

My health information related to the dates: _____

I understand that

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment, payment or enrollment for healthcare.
- I may revoke this authorization at any time before the information I have requested is released by providing a written notice of revocation.
- I may see and obtain a copy of the information described on this form if I request it.
- I may request a copy of this form after I sign it.
- A copy fee of 6 dollars and 50 cents may be assessed for medical records.
- HIPAA allows 30 days to process medical records.
- This authorization expires on / / , one year after signed.

Signature of Patient / Representative: _____ Date:_____

Relationship of representative to patient if applicable: _____

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following: Signature of Patient / Representative Relationship to patient