

LAKE NORMAN DERMATOLOGY, P.A.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____	Date of birth: _____
Address: _____	
City, State, Zip Code: _____	
SS #: _____	Patient's phone #: _____
Date of Request: _____	Date Needed: _____

I authorize Lake Norman Dermatology to: OBTAIN INFORMATION / RELEASE INFORMATION (CIRCLE ONE)	
Name of provider or facility: _____	
Address: _____	
City, State, Zip Code: _____	
Phone: _____	Fax: _____

PURPOSE FOR THIS REQUEST: Health care Insurance Coverage Personal Other

TYPE OF RECORDS REQUESTED:

- Immunization history
- All medical history related to a specific condition: _____
- All medical history from the dates: _____
- Treatment summary (includes history/physical, laboratory tests, radiology reports, operative reports, pathology)
- Specific information
 - Procedure report History and Physical Physical Therapy Laboratory/Pathology test results
 - X-ray reports Other: _____

AUTHORIZATION VALID FOR:

- This request only
- One year from the date of this authorization **OR** for all records prior to the date _____
- This request and for medical records of any future treatment of the type described until _____

I understand that:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment **information requires additional authorization.**

Charge for this service is as follows, according to North Carolina Law:
.75 per page 1 to 25, .50 per page 26 to 100, .25 per page 101 and over
with a \$10.00 minimum plus postage fees

Patient/Legal Guardian Signature

Date

Witness

Date

For Office Use Only:

Date sent: _____ by: _____
via: mail fax
 picked up by: _____