U.S. DERMATOLOGY partners

MEDICAL RECORDS RELEASE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Please print

I hereby authorize use or disclosure of the names individual's health information as described below:

Patient Name_____ Date of Birth_____/_____/_____
Last First Middle Month Day Year

Patient Address_____
Street City St Zip

Patient Social Security #_____/_____/_____ Patient Telephone # (____)_____

The following individual or organization is authorized to make the disclosure:

☐ U.S. Dermatology Partners may disclose protected health information of the above named patient *to* the individual or organization listed below.

☐ The individual or organization listed below may disclose protected health information *to* U.S. Dermatology Partners .

Name of individual or organization:_____

Address of individual or organization:_____

Phone/Fax of individual or organization: Phone#_____Fax #_____

Records may be: ☐ Mailed to above address ☐ Faxed to above # ☐ Electronic (only available in patient portal)

Purpose of Use/Disclosure: ☐Patient Access ☐To Doctor ☐To Insurance ☐To Attorney ☐Other_____

Treatment Dates of protected health information to be disclosed: From_____to_____

Information to be Disclosed: ☐Medical Records ☐Billing Records ☐Pathology Report ONLY

This is ☐ A one-time disclosure ☐ A continuing disclosure for 12 months

I understand that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization, and the requester may be provided a copy of this authorization.
I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for records. Medical record fee is $25 for the first 20 pages and $.50 for each additional page. Pathology Report ONLY fee is $10.00.
I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality.
I hereby release U.S. Dermatology Partners from any legal responsibility or liability for disclosure that may arise as a result of the use of the information contained in the Protected Health Information.
I understand that the information in my record may include information relating to sexually transmitted diseases, IDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment.
***Enrollment in EMA Patient Portal is required in order to access your information electronically.*

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of employee processing use/disclosure of PHI. **Date**

Revised 7/17