Authorization to Release Health Information

Patient Information:

Name of Patient: ____ Date of Birth: _____/______/__________

Address: ____

City: ____ State: _________ Zip: _____________________________

At my request you may release the following information to:

Central Dermatology Center, PA **Attn:** _______________________________
2238 Nelson Highway, Suite 100
Chapel Hill, NC 27517
Phone: 919-401-1994 Fax: 919-401-1924

□ Entire Medical Record □ Financial Records □ Office Visit Notes

□ On Site record review by the patient □ Mole Maps

□ Diagnostic Studies (please specify): ____

□ Other as listed: ____

Entity or person who will release the information:

Name:____

Address:____

City: ____ State: _________ Zip: _______________________________

Phone ____ Fax: ____

□ Send the requested information electronically. Email Address: ____

□ By checking this box, I acknowledge that I understand that email communication is not sent in an encrypted manner and there is a risk that it could be accessed inappropriately.

□ Mail the records to the entity listed above

□ Fax the requested records to the entity listed above

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include communicable disease diagnosis.

____ Date: _______________________________

(Signature of patient or Personal Representative)

____

(Description of Personal Representative's Authority – attach documentation if necessary)

Revised 6-8-16