Authorization to Use or Disclose Health Information

Patient Name: _____ **Date of Birth:** _____
Print full name

I authorize the use or disclosure of the above named individual's health information as described below.

1. The type of information to be used or disclosed is as follows: **Please note that standard rates for copying may apply **

   □ My complete medical records **or** check the appropriate boxes below,

□ Clinic Note	□ Progress Note	□ Anesthesia/Sedation Record	□ Other (Specify below):
□ Prescription History	□ Consultation Note	□ Bill for Service	
□ Laboratory Result	□ Radiology Report	□ History and Physical Report	
□ Operative/Procedure Report	□ Pathology Report	□ Paper copies of records (otherwise records will be on disc)	

   The above information can be released from the date of _____through _____
   Or □ the period of time encompassing all dates of service at The Skyland Dermatology.

2. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

3. The information identified above may be used or disclosed to the following individual(s) or organization(s):

   Name of Organization or Individual: _____

   Address: _____

   Phone Number: _____ Fax Number: _____

4. This information for which I am authorizing disclosure will be used for the following purpose:
   □ my personal use □ sharing with other health care providers □ workman's compensation
   □ other: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. This authorization will expire on □ _____ (Date) or □ is valid as long as I am a patient of this practice. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

7. I understand that once the above information is disclosed, the recipient may redisclose it, and the federal privacy laws or regulations may not protect the information.

8. I understand the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

_____ _____
Signature of patient or legal representative Date

_____
If signed by legal representative, relationship to patient

_____ _____
Signature of witness Date

Submit this form by emailing to records@cmdskin.com, faxing to (828) 648-0677, or mailing to
Skyland Dermatology Medical Records Request, 78 Long Shoals Rd, Arden, NC 28704