

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize the release of medical information as indicated below:

To: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
\_\_\_\_\_

- I would like to pick up my records  
 I would like to have my records mailed to the indicated address above
- I would like to have my records faxed to the indicated fax number above

Records to be released:

- Office Notes  
 Consultation Notes  
 Pathology/Biopsy Report  
 Other

List date(s) below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Purpose of the release:

- For another doctor  
 Personal use  
 Other: \_\_\_\_\_
- For transferring care  
 For insurance

May not include mental health treatment records, psychological services and social services information, including communicate made by patient to a social worker or psychologist.

May not include HIV/AIDS, substance abuse or generic information except for any of this additional information that I include below.

**Expiration date: This authorization shall expire in 14 days. After this date, Village Dermatology & Cosmetic Surgery, LLC, can no longer use or disclose patient's protected health information without first obtaining a new authorization form.**

I understand this Authorization can be revoked at any time according to Village Dermatology & Cosmetic Surgery, LLC's privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Village Dermatology & Cosmetic Surgery, LLC and may potentially be re-disclosed by the party who received these records. Village Dermatology & Cosmetic Surgery, LLC, its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

\_\_\_\_\_  
Signature of the patient/legal representative and relationship to patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the provider

\_\_\_\_\_  
Date