AUTHORIZATION FOR MEDICAL RELEASE OF INFORMATION

Palmetto Dermatology
3574 Sunset Blvd
West Columbia, SC 29169
803-796-2500
www.palmettodermatology.com

Patient Name: _____**Date of Birth**_____ **Address:** _____

City/State/Zip:_____ **Telephone**_____

I authorize the release of medical information as indicated below:

From: (Name/Address) _____ **To: (Name/Address)** _____

_____ _____

_____ _____

Phone/Fax #_____ **Phone/Fax #** _____

☐ I would like to pick up my records: please call me at _____
☐ I would like to records mailed (please indicate address above)

What to Release: Please choose the records you would like released:

☐ Outpatient notes
☐ X-Ray report(s)
☐ Pathology Report(s)
☐ Other Specify_____
☐ Laboratory reports
☐ X-ray Film(s)
☐ Immunization record
☐ All medical records
☐ Billing records

NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV tests	☐ Yes	☐ No/NA
The diagnosis or treatment of drug and/or alcohol abuse	☐ Yes	☐ No/NA
The treatment and/or consultation for mental health or psychiatric disorders	☐ Yes	☐ No/NA
Psychotherapy notes	☐ Yes	☐ No/NA

Purpose of the release: Please indicate the reason for this release

☐ For another doctor
☐ Use in a lawsuit
☐ Follow-up related to an injury
☐ Personal use
☐ To obtain disability
☐ Worker's care
☐ Armed forces requirement
☐ Other _____

Format of the release:

☐Hardcopy format
☐Portable media device
☐Email: _____

I understand that electronic media, and delivery methods such as unencrypted email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of Palmetto Dermatology. I agree to assume such risks personally, and to hold Palmetto Dermatology harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing Palmetto Dermatology to transmit or deliver such information electronically.

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

☐ Please change the expiration date to last for _____days.

I understand this Authorization can be revoked at any time according the Palmetto Dermatology 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 Palmetto Dermatology and may potentially be re-disclosed by the party who received these records. Palmetto Dermatology, 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 understand that I have the right to:

- Inspect or copy the Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Have an electronic copy of my medical records, or a portion thereof, transmitted to any third party or person I designate.
- Refuse to sign this Authorization.

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 Patient _____ Date: _____

Signature of Legal Representative _____

Date: _____

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FOR OFFICE USE ONLY

Received by: **Date Received:** **Time Received:**

Action(s) Taken:

Disclosure Media: **Hardcopy** **Memory Stick** **CD-ROM** **Email** **Other (describe)** **Discloser's Signature:**