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Authorization to Release Healthcare Information

Patient Name: _____ DOB: _____
Previous Name (*if any*):_____Phone:_____
Are you authorizing the release of your own records? □ Yes □ No
If not, what is your name and relationship to the patient?
Name:_____ Relationship:_____

Information to be released by:
Organization:_____
Name: _____
Address: _____
_____
Phone:_____
Fax:_____

Information to be released to:
Organization:_____
Name: _____
Address: _____
_____
Phone:_____
Fax:_____

Information to be released: ***please check all that apply***
□ Complete Chart Record **(This is limited to the two (2) most current years of information including Laboratory, X-ray, and Pathology Reports, but does not include billing information)**
□ Health Care Information in my medical record relating to treatment/condition OR for the dates of: _____

Billing Records:
□ All Records (**This is limited to the two (2) most current years of information)**
□ For the treatment/condition OR dates of:_____
Requests for information older then two (2) years with be subject to copying charges, $1.04/page for the first thirty (30) pages and $0.79/page thereafter.

Uses and Disclosures requiring specific authorization: Unless specifically **EXCLUDED** this authorization of Health Information may include documentation regarding the referral, diagnosis and treatment information relation to:
□ HIV/AIDS □ Sexually transmitted Disease □ Mental Health or Illness □ Drugs and/or Alcohol abuse □ Reproductive Care (Minors only)

Purpose for which disclosure is being made:
□ Concurrent Care □ Transfer of Care □ Insurance □ Personal Use

My Rights:
I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do it in writing and present my written revocation to Carla J. Bauman M.D. Medical and Cosmetic Dermatology. If information has already been released based on this release, the revocation will not apply to that information. I understand 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. I understand that one the information is disclosed, federal privacy laws or regulations may not protect the information and the recipient may re-disclose it.

I authorize release of my medical records, as described above. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, however I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

_____ _____
Signature of patient or Legal authorized representative **Date**

Expiration: 30 days after the date that it is signed.