CARLA J. BAUMAN, M.D.
MEDICAL & COSMETIC DERMATOLOGY

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***
Medical Records
□ Complete medial chart record **(excluding billing information)**
□ Partial medical chart record **(excluding billing information)** for the dates:
_____

Billing Records:
□ All billing records (**This is limited to the two (2) most current years of information)**
□ Partial billing record for the dates:_____

The information to be released may include behavior and/or mental health care, and HIV test results.

Purpose for which disclosure is being made:
□ Concurrent Care □ Transfer of Care □ Insurance □ Personal Use □ Legal □Workers' Compensation
□ Other, specify:_____

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 MD PS. 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: 120 days after the date that it is signed unless revoked.
Charges: I may be charged for copies in accordance with state law

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