

Authorization to Review or Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____
Address _____ Phone _____
City, State, Zip _____

I authorize the practice below to release my health information:

Please forward/release my health information to:

I request a copy or summary of the following medical records:

- | | |
|--|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Medication Allergies |
| <input type="checkbox"/> Biopsy Report(s) | <input type="checkbox"/> Surgical Procedure(s) |
| <input type="checkbox"/> Lab Report(s) | <input type="checkbox"/> Information necessary to file cancer policy |
| <input type="checkbox"/> Consultation Report(s) | |
| <input type="checkbox"/> Other: _____ | |

For dates of service from _____ to _____.

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to **Ginger Teachey, Practice Administrator, Cary Skin Center, PA, 200 Wellesley Trade Lane, Cary, NC 27519.**

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

For Office Use Only

- Records faxed Date _____ Initials _____ **and** Fax Confirmed Date _____ Initials _____
- Records mailed Date _____ Initials _____
- Records handed to pt Date _____ Initials _____