Phone: (919) 363-7546 Fax: (919) 363-3616

ACMS American College of Mohs Surgery
Fellowship trained skin cancer and reconstructive surgeons

CARY SKIN CENTER
Skin Cancer Center

Accredited by
Accreditation Association for Ambulatory Health Care, Inc.

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:

- ☐Complete Medical Record
- ☐Biopsy Report(s)
- ☐Lab Report(s)
- ☐Consultation Report(s)
- ☐Medication Allergies
- ☐Surgical Procedure(s)
- ☐Information necessary to file cancer policy
- ☐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.**

______________________ Date ____________

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______

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