Cary: (919) 363-7546 Fax: (919) 363-3616
Pinehurst: (910) 295-1761 Fax: (910) 295-2937

Authorization for Release of Medical Records/Request for Access to Protected Health Information

Patient Information:

Name: ________________________________ Date of Birth: ______________

Address: ________________________________ Phone: ____________________

City, State, Zip: ____________________________

I authorize Cary Skin Center, PA to release my health information.

Please specify date(s) of service requested: ________________________________

Recipient name, address, phone:

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Please specify the reason for this request:

- ☐ Further Treatment
- ☐ Legal proceeding
- ☐ Insurance claim/Cancer Policy
- ☐ *Other (please list below)

*____

Please specify if any restrictions or limitations apply to the release of your medical records:

____

I hereby authorize the release of my medical records as specified above. I understand that this authorization complies with regulations ensuring the timely and appropriate release of medical records.

Revocation Clause: I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken based on this authorization.

Requests for medical records, which come from certain entities such as insurance companies/attorneys may be charged a fee for reproduction costs.

Patient/Legal Guardian Signature: **Date:**

For Office Use Only

☐Records Faxed ☐Records Mailed ☐Records Securely Emailed ☐Records Handed to Pt/Personal Representative

Date________ Initials_______

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