108 Dornach Way, Advance, N.C. 27006
(T) 336-940-2407; (F) 336-940-2409

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION – *PATIENT REQUEST*

By signing this authorization, I authorize Davie Dermatology and the Med Spa to provide me with a copy of my medical records as follows.

(Check each appropriate items to release)

Office notes _____ Laboratory Reports_____ Operative Report _____ Pathology Reports _____

Treatment dates (if certain dates are wanted _____

This authorization will expire on _____
Date

I understand that I will receive an invoice for copies of my medical records that must be paid prior to the release of the medical records.
Rates: 1-25 Pages= $10.00 26-100 Pages= $30.00 100+ Pages+ $60.00

Davie Dermatology will not share your health information except by ways listed in the "Notice of Privacy Practices" by Davie Dermatology. You may cancel this authorization at any time by submitting your request in writing to the Privacy Officer at Davie Dermatology. When your information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You do not have to sign this authorization in order to receive treatment from Davie Dermatology.

Address where the records should be mailed:
_____
_____
_____
_____

Signed by: _____
Signature of Patient or Legal Guardian

_____ _____
Name of Patient Date

Date of Birth _____(If not patient signature, relationship to patient) _____