Pacific Skin Institute
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone (H): _____ **Phone (M):** _____

Address: _____ **City/ State/ Zip:** _____

Please Note: Copy fee may be charged for medical records

Above listed patient authorizes the following healthcare facility to make a records disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City/ State/Zip: _____

Dates & Type of Information to disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates (other): _____
- ☐ Specific Information Requested: _____

_____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care
- ☐ Referral
- ☐ Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless otherwise specified.

I understand that the information in my health record may include information relating to sexual transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol & drug abuse.

This information may be disclosed and used by the following individual and organization:

Release to: _____ **Phone:** _____

Address: _____

- ☐ **Mail Records**
- ☐ **Fax Records**

City/ State/ Zip: _____

Fax: _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department, I understand that the revocation will not apply to information that has already been released I response to this authorization. I understand that 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. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____ **.If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the signed date.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand, that I may inspect or obtain a copy od the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the authorized individual or organization making disclosure. **I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

_____ _____

Patient/ Guardian/ Authorized Representative Signature **Date**

_____ _____

Printed Name of Authorized Reprsentative & Relationship **Witness Signature**