Central Dermatology Center

Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

At my request you may release the following information to:

Central Dermatology Center, PA **Attn:** _____
2238 Nelson Highway, Suite 100
Chapel Hill, NC 27517
Phone: 919-401-1994 Fax: 919-401-1924

☐ Entire Medical Record ☐ Financial Records ☐ Office Visit Notes

☐ On Site record review by the patient ☐ Mole Maps

☐ Diagnostic Studies (please specify): _____

☐ Other as listed: _____

Entity or person who will release the information:

Name:_____

Address:_____

City: _____ State: _____ Zip: _____

Phone _____ Fax: _____

☐ Send the requested information electronically. Email Address: _____

☐ By checking this box, I acknowledge that I understand that email communication is not sent in an encrypted manner and there is a risk that it could be accessed inappropriately.

☐ Mail the records to the entity listed above

☐ Fax the requested records to the entity listed above

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- Information used or 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 may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include communicable disease diagnosis.

_____ Date: _____

(Signature of patient or Personal Representative)

_____

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

Click Here To Submit Form **or email to medicalrecords@centraldermcenter.com**

6-8-16