Bluegrass Dermatology and Skin Surgery Center, PSC

Authorization for Release of Protected Health Information

DATE: _____

PATIENT'S NAME: _____ PATIENT'S DATE OF BIRTH: _____

Purpose of release: [ ] Request of individual [ ] Transfer of care [ ] Other: _____

I, _____, HEREBY AUTHORIZE:

NAME: _____

ADDRESS: _____ PHONE: _____

TO RELEASE MY RECORDS TO BLUEGRASS DERMATOLOGY

Method of Receiving: [ ] Mail Record [ ] I will pick up [ ] FAX (*Providers only)

If you prefer us to mail your medical records please list the address: _____
_____

If you would prefer we fax your medical records please list the appropriate fax number: _____

[ ] Records covering period of time: _____ to _____ [ ] All dates of treatment
[ ] Records regarding treatment for the following condition(s) or injury(ies) **ONLY**: _____
[ ] Other: _____
[ ] Any and all medical records in the possession of the medical office including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.

1. I understand this is the minimum amount of information necessary for the purpose described above. No other information will be disclosed.
2. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Office Manager at the adress noted at the bottom of this form. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

_____ _____ _____
Signature of Patient / Parent or Guardian Today's Date Contact Telephone Number

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