



Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

At my request, Central Dermatology Center, PA may release the following information to the entity listed below:

- ☐ Entire Medical Record ☐ Financial Records ☐ Office Visit Notes
- ☐ On Site record review by the patient ☐ Mole Maps* (If you check this box, please read & initial below.)
- ☐ Diagnostic Studies (please specify): _____
- ☐ Other as listed: _____

*I understand that all Mole Maps are digital and will be supplied on CD or DVD and must be picked up at our office by the patient only. Upon pickup I am assuming complete responsibility for the security of my Mole Map images and am releasing Central Dermatology Center from any liability related to my Mole Map. _____ Patient Initials

Entity or person who will receive the information:

(If you are requesting records be mailed directly to you, please write "Patient" in the name and complete address only if different from your address above.)

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 re-disclosure 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.

Fees:

Upon submission of this form, you will receive a message through your portal from our medical records staff detailing fees and instructions for submitting payment. Your medical records will be released once associated fees have been paid in full. The fees charged will be as follows: The maximum fee for each request shall be seventy- five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page for pages 26 through 100, and twenty-five cents (25¢) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars (\$10.00), inclusive of copying costs. Faxing requests for transfer of care will be \$10.00.

(Signature of patient or Personal Representative)

Date: _____

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

Once completed, please email this form to medicalrecords@centraldermcenter.com.