

MEDICAL RECORDS RELEASE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Social Security #	Please print I hereby authorize use or disclosure of the names inc	dividual's health inform	nation as des	cribed below:
Patient Address Street City St Zp	Patient Name	Date of Birt	th /	/
Patient Social Security #	Last First	Middle	Month	Day Year
Patient Social Security #	Patient Address			
The following individual or organization is authorized to make the disclosure: U.S. Dermatology Partners may disclose protected health information of the above named patient to the individual or organization listed below. The individual or organization listed below may disclose protected health information to U.S. Dermatology Partners. Name of individual or organization: Address of individual or organization: Phone/Fax of individual or organization in patient portally Pax #	Street	City	St	Zip
□ U.S. Dermatology Partners may disclose protected health information of the above named patient to the individual or organization listed below. □ The individual or organization listed below may disclose protected health information to U.S. Dermatology Partners. Name of individual or organization: Address of individual or organization: Phone/Fax of individual or organization: Phone/Pax of individual	Patient Social Security #//	_ Patient Telephone #	()	
U.S. Dermatology Partners . Name of individual or organization: Address of individual or organization: Phone/Fax of individual or organization: Phone/Fax of individual or organization: Phone# Fax # Records may be: □ Mailed to above address □ Faxed to above # □ Electronic (only available in patient portal) Purpose of Use/Disclosure: □ Patient Access □ To Doctor □ To Insurance □ To Attorney □ Other □ Treatment Dates of protected health information to be disclosed: From □ to □ Information to be Disclosed: □ Medical Records □ Billing Records □ Pathology Report ONLY This is □ A one-time disclosure □ A continuing disclosure for 12 months I understand that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization, and the requester may be provided a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for records. Medical record fee is \$25 for the first 20 pages and \$.50 for each additional page. Pathology Repo ONLY fee is \$10.00. I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute breach of my right to confidentiality. I hereby release U.S. Dermatology Partners from any legal responsibility or liability for disclosure that may arise as a result of the use of the information contained in the Protected Health Information. I understand that the information in my record may include information relating to sexually transmitted diseases, IDS, or HIV infection. It may also include information about behavioral or mental health services of treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. **Enrollment in EMA Patient Portal is required in order to access your inf	☐ U.S. Dermatology Partners may disclose protected he			patient to the
Address of individual or organization: Phone/Fax of individual or organization: Phone# Fax # Fax # Records may be: Mailed to above address Faxed to above # Electronic (only available in patient portal) Purpose of Use/Disclosure: Patient Access To Doctor To Insurance To Attorney Other Treatment Dates of protected health information to be disclosed: From to Information to be Disclosed: Medical Records Billing Records Pathology Report ONLY This is A one-time disclosure A continuing disclosure for 12 months I understand that I (or the person authorized to act on my behalf) ame entitled to receive a copy of this authorization, and the requester may be provided a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for records. Medical record fee is \$25 for the first 20 pages and \$.50 for each additional page. Pathology Repo ONLY fee is \$10.00. I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute breach of my right to confidentiality. I hereby release U.S. Dermatology Partners from any legal responsibility or liability for disclosure that may arise as a result of the use of the information contained in the Protected Health Information. I understand that the information in my record may include information relating to sexually transmitted diseases, IDS, or HIV infection. It may also include information about behavioral or mental health services of treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. **Enrollment in EMA Patient Portal is required in order to access your information electronically.	· · · · · · · · · · · · · · · · · · ·	se protected health infor	mation to	
Phone/Fax of individual or organization: Phone#	Name of individual or organization:			
Records may be: Mailed to above address	Address of individual or organization:			
Purpose of Use/Disclosure: Patient Access To Doctor To Insurance To Attorney Other Treatment Dates of protected health information to be disclosed: From to Information to be Disclosed: Medical Records Billing Records Pathology Report ONLY This is A one-time disclosure A continuing disclosure for 12 months I understand that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization, and the requester may be provided a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for records. Medical record fee is \$25 for the first 20 pages and \$.50 for each additional page. Pathology Repo ONLY fee is \$10.00. I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute breach of my right to confidentiality. I hereby release U.S. Dermatology Partners from any legal responsibility or liability for disclosure that may arise as a result of the use of the information contained in the Protected Health Information. I understand that the information in my record may include information relating to sexually transmitted diseases, IDS, or HIV infection. It may also include information about behavioral or mental health services of treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. "Enrollment in EMA Patient Portal is required in order to access your information electronically.	Phone/Fax of individual or organization: Phone#	Fax	.#	
Treatment Dates of protected health information to be disclosed: From	Records may be: \square Mailed to above address \square Faxed	to above # 🛚 Electronic	C (only available	in patient portal)
Information to be Disclosed: Medical Records Billing Records Pathology Report ONLY This is A one-time disclosure A continuing disclosure for 12 months I understand that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization, and the requester may be provided a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for records. Medical record fee is \$25 for the first 20 pages and \$.50 for each additional page. Pathology Repo ONLY fee is \$10.00. I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute breach of my right to confidentiality. I hereby release U.S. Dermatology Partners from any legal responsibility or liability for disclosure that may arise as a result of the use of the information contained in the Protected Health Information. I understand that the information in my record may include information relating to sexually transmitted diseases, IDS, or HIV infection. It may also include information about behavioral or mental health services of treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. **Enrollment in EMA Patient Portal is required in order to access your information electronically.	Purpose of Use/Disclosure: □Patient Access □To Doct	or □To Insurance □To	Attorney □C	other
This is \square A one-time disclosure \square A continuing disclosure for 12 months I understand that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization, and the requester may be provided a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for records. Medical record fee is \$25 for the first 20 pages and \$.50 for each additional page. Pathology Repo ONLY fee is \$10.00. I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute breach of my right to confidentiality. I hereby release U.S. Dermatology Partners from any legal responsibility or liability for disclosure that may arise as a result of the use of the information contained in the Protected Health Information. I understand that the information in my record may include information relating to sexually transmitted diseases, IDS, or HIV infection. It may also include information about behavioral or mental health services of treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. **Enrollment in EMA Patient Portal is required in order to access your information electronically.	Treatment Dates of protected health information to be dis	sclosed: From	to	
I understand that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization, and the requester may be provided a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for records. Medical record fee is \$25 for the first 20 pages and \$.50 for each additional page. Pathology Repo ONLY fee is \$10.00. I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute breach of my right to confidentiality. I hereby release U.S. Dermatology Partners from any legal responsibility or liability for disclosure that may arise as a result of the use of the information contained in the Protected Health Information. I understand that the information in my record may include information relating to sexually transmitted diseases, IDS, or HIV infection. It may also include information about behavioral or mental health services of treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. **Enrollment in EMA Patient Portal is required in order to access your information electronically.	Information to be Disclosed: ☐Medical Records ☐Bi	illing Records □Path	ology Report (ONLY
authorization, and the requester may be provided a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for records. Medical record fee is \$25 for the first 20 pages and \$.50 for each additional page. Pathology Repo ONLY fee is \$10.00. I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute breach of my right to confidentiality. I hereby release U.S. Dermatology Partners from any legal responsibility or liability for disclosure that may arise as a result of the use of the information contained in the Protected Health Information. I understand that the information in my record may include information relating to sexually transmitted diseases, IDS, or HIV infection. It may also include information about behavioral or mental health services of treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. **Enrollment in EMA Patient Portal is required in order to access your information electronically.	This is □ A <u>one-time disclosure</u> □ A <u>continuing disc</u>	closure for 12 months		
Signature of Patient or Legal Representative	authorization, and the requester may be provided a copy I also understand that I am entitled to inspect my record records. Medical record fee is \$25 for the first 20 pages ONLY fee is \$10.00. I understand that I may revoke this authorization in writi been made prior to my revocation in reliance on this authorization of my right to confidentiality. I hereby release U.S. Dermatology Partners from any learise as a result of the use of the information contained in understand that the information in my record may includiseases, IDS, or HIV infection. It may also include infort treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this healt authorization. I do not need to sign this form to ensure the	of this authorization. Its and that a reasonable and \$.50 for each addition of a control of the	fee may be clonal page. Page the extent that release shall noting for disclosuration. The sexually transport or mental hear	harged for thology Repor at release has not constitute a ure that may asmitted alth services or
organizatio of Fationic of Logar Reproductive	Signature of Patient or Legal Representative	Dat	 :e	