Carolinas Dermatology Group, P.A. 1706 St. Julian Place, Columbia SC 29204 (803) 771-7506 (803) 771-9455 Fax

Release of Information

PLEASE BE SURE TO FILL THE FORM OUT COMPLETELY, TO ENSURE YOUR REQUEST IS PROCESSED CORRECTLY

Chart #: _____
Patient Name: _____
Address: _____
_____
Date of Birth: _____

Were you seen in the office within the past week? __ yes __ no
***if yes –it could take up to 1-2 weeks before receiving records**

I hereby request and authorize _____ to release/disclose the above named individual's health information to:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

***Please provide all info of where you want your records sent, including address, phone # and fax #* Thank you**

Information to be released/disclosed: (Check all that apply)
__Complete Medical record (must be specific on exact records that are needed) _____
__Pathology/Biopsy Report(s)
__Lab Report(s)
__Consultation Report(s)
__Surgical Procedure(s)
__Other _____

This form will be valid for: (Check the one that applies) ***Please be specific if checking "other"**
__Dates of Service –To: _____ From: _____
__Treatment(s): _____
__Upon completion of releasing of the records
__Until I revoke this consent in writing ***unless you choose specific dates of service, only then does the release expire**

I understand that the information in my medical record may include information relating to sexually 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 and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise.

Restrictions

- According to the Federal and State regulations, if the medical information requested, relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied with a statement limiting disclosure to third parties as required by law.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Confidentiality Requirements.
- I realize Carolinas Dermatology Group, P.A. has the responsibility to maintain and confidentiality of the medical records in its possession. I understand that once the information is disclosed the recipient may re-disclose it and federal privacy laws or regulations may not protect the information. Carolinas Dermatology Group, P.A. will not be held responsible for any subsequent disclosure by the recipient of the health information.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility of benefits.
- **Carolinas Dermatology has 48 business hours to process all records request, from the date the request was received by our office.**
- I have read and understand Carolinas Dermatology Group, P.A.'s policy on releasing my personal health information.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____