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

Carolinas Dermatology Group of Florence 1929 Mountain Laurel Court (843) 407-2030 (843) 407-2025 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 2-4 weeks before receiving records**

I hereby request and authorize ____________________ to release/disclose the above named individual's health information to:

Name: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________
Email: ____________________

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

********I understand that if I choose to have my records processed through email, that it is not secure and that Carolinas Dermatology cannot guarantee the safe delivery of my records through email processing*********

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)
__Surgical Procedure(s) __Consultation Report(s)

__Other (please explain) ____________________

******If this is for a Cancer Policy, please be specific on the dates of service needed for the policy******

This form will be valid for: (Check the one that applies)
__Dates of Service –To: __________ From: __________
__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.
- I have read and understand Carolinas Dermatology Group, P.A.'s policy on releasing my personal health information.
- **FMLA paperwork is required to be sent directly to your place of employment; a copy will be sent to you via mail, once your place of employment has received the finalized paperwork**

Patient Signature: ____________________ Date: ____________________

Witness Signature: ____________________ Date: ____________________

Carolinas Dermatology has 48 business hours to process all records request, from the date the request was received. Some requests may take up to 2-4weeks to process, depending on the type of request and the size of your file.