Name:
DOB:
Chart:
Age:
Date:

Pinehurst Dermatology
A PROFESSIONAL ASSOCIATION
120 Braemar Court Pinehurst NC 28374

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patient's full name) _____ Birth Date (Mo/Day/Yr) _____

(Street or Mailing Address) _____ Social Security Number _____

(City, State, Zip Code) _____ Home Telephone # W/AREA CODE _____

At the request of the individual, I _____ (Patient's Name) do hereby authorize _____ to release:

- ☐ Progress notes
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Biopsy Report(s)
- ☐ Surgical/Operative Notes
- ☐ History/Physical
- ☐ Lab Report(s)
- ☐ Pathology Report(s)
- ☐ Radiology Report(s)

Other _____

FOR DATES OF SERVICE: from _____ to _____

☐ I do ☐ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street or Mailing Address

_____
City, State Zip Code

The information will be used or disclosed for the following purpose:

- ☐ Referral to specialist
- ☐ Insurance
- ☐ Personal
- ☐ Continuing Care
- ☐ Legal Investigation
- ☐ Workers Comp
- ☐ Change of Doctor
- ☐ Disability Determination

Other (specify) _____

I hereby authorize disclose of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed my be subject to re-disclosure by the person or class of persons of facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

SIGNATURE OF INDIVIDUAL OR GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE — DATE