

Name:
DOB:
Chart:
Age:
Date:



**Pinehurst
Dermatology**
A PROFESSIONAL ASSOCIATION

185 Page Road Suite A, 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 _____ do hereby authorize _____
(Patient's Name)

to release:

- | | | |
|---|---|--|
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Biopsy Report(s) | <input type="checkbox"/> Lab Report(s) |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Surgical/Operative Notes | <input type="checkbox"/> Pathology Report(s) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History/Physical | <input type="checkbox"/> Radiology Report(s) |
| Other _____ | | |

FOR DATES OF SERVICE:

I do I do NOT

from _____ to _____
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:

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Referral to specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal | <input type="checkbox"/> Continuing Care |
| <input type="checkbox"/> Legal Investigation | <input type="checkbox"/> Workers Comp | <input type="checkbox"/> Change of Doctor | <input type="checkbox"/> 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