Pinehurst Dermatology
120 Braemar Court
Pinehurst, NC 28374
(910) 295-5567 • (910) 295-3315 - fax

Authorization to Use or Disclose Health Information

Patient Name:_____ **Date of Birth:**_____
Please print full name

1. I authorize the use or disclosure of the above named individual's health information by Pinehurst Dermatology as described below.

2. The type of information to be used or disclosed is as follows: **Please note that standard rates for copying may apply **

□ My complete medical records **or** check the appropriate boxes below,

□ Clinic Note	□ Progress Note	□ Anesthesia/Sedation Record	□ Other (Specify below):
□ Prescription History	□ Consultation Note	□ Bill for Service	
□ Laboratory Result	□ Radiology Report	□ History and Physical Report	
□ Operative/Procedure Report	□ Pathology Report	□ Paper copies of records (otherwise records will be on disc)	

The above information can be released from the date of _____through _____
Or □ the period of time encompassing all dates of service at Pinehurst Dermatology.

3. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

4. The information identified above may be used or disclosed to and/ or requested from the following individual(s) or organization(s):

_____
Name of Organization or Individual

_____
Address

_____ _____
Phone Number Fax Number

5. This information for which I am authorizing disclosure will be used for the following purpose:
□ my personal use □ sharing with other health care providers □ workman's compensation
□ other: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This authorization will expire on □ _____ (Date) or □ is valid as long as I am a patient of this practice. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

8. I understand that once the above information is disclosed, the recipient may redisclose it, and the federal privacy laws or regulations may not protect the information.

9. I understand the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

_____ _____
Signature of patient or legal representative Date

_____
If signed by legal representative, relationship to patient

_____ _____
Signature of witness Date