Dermatology Specialists of Greater Cincinnati

Skin Care for the Entire Family

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MEDICAL RECORDS RELEASE FORM

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) about me to _____.
Mailing Address: _____
Fax Number:_____

The information to be released is (state specific documents, time period, etc.):

_____

The information will be used or disclosed for the following purpose: *If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.*

Continued Care _____ Insurance_____ Legal _____ Transfer _____ Personal_____ Request of the Individual_____

This authorization will expire 90 days from the date I signed the consent. I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Jessica Gross the Privacy Officer at 7794 Five Mile Road, Suite 240 Cincinnati, OH 45230.

_____ _____ _____
Patient Name | Date of Birth | Relationship to Patient

_____ _____
Signature of Patient or Legal Guardian | Date

_____
Print Name of Patient or Legal Guardian

Account Number: _____

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION