AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT INFORMATION

Patient Name (as it appears on Driver's License or Photo ID): _____

Patient Date of Birth (MM/DD/YYYY): _____

I request and authorize **Epiphany Dermatology** *to release healthcare information of the patient named above to:*

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

PLEASE SEND COPIES OF THE FOLLOWING MEDICAL RECORDS (CHECK ALL THAT APPLY):

○ *Office Consult notes* ○ *Pathology report(s)* ○ *Lab report(s)* ○ *Entire Medical Records*

○ *Other:* _____

I UNDERSTAND THE FOLLOWING

I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.

I understand that the healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may refuse to sign this authorization.

SIGNATURE

Patient / Guardian Signature: *Date:*

*Exp Date (One year from date of request):*_____