

Breezy Point Dermatology

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Authorized Release of Medical Records

Please check and fill out areas as needed:

Date: _____

Patient Name: _____ Date of birth: _____

Authorization to **release** my medical records to **myself**.

Fax

Mail

Pick up:

Fax: _____ Attn: _____ Date of pick up: _____

Phone: _____ Address: _____

Attn: _____

Authorization to **release** my medical records to **another facility**.

Fax

Mail

Pick up:

Fax: _____ Attn: _____ Date of pick up: _____

Phone: _____ Address: _____

Attn: _____

Authorization to **request** my medical records from **another facility**.

To: _____

Tel: _____ Fax: _____

INFORMATION TO BE RELEASED INCLUDES:

Chart notes

Operative Reports

Lab/Pathology Reports

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Signature: _____

Date: _____

Patient or Legally Authorized Representative

