

Columbia Dermatology & Aesthetics

Medical Records Release

Name of Patient: _____

Address: _____

Date of Birth: _____ SSN: _____

- Clinical/ Progress Notes Operative Reports
 Laboratory Reports Pathology Reports
 All of the Above

I authorize Columbia Dermatology to **send** a copy of my medical records to:

I authorize Columbia Dermatology to **obtain** a copy of my medical records from:

1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
2. I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be disclosed.
3. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent in writing to the address noted at the bottom of the form.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5. I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted on this form.
6. I understand that this authorization will expire in 90 days after signed unless an earlier date is specified here. _____

Signature: _____ Date: _____