Columbia Dermatology, LLC

Jessica Burgy, M.D.
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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 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 o 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: _____

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