



Beauty thru Health Dermatology, PC

Individual Request for Protected Health Information

Last: _____ First: _____

Social Security # XXX - XX- _____ Date of Birth: ____/____/____

Address: _____

Home #: _____ Work #: _____

Release Records From:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Release Records To:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Method of delivery of requested records:

• Mail • Electronic delivery, recipient email: _____

I request a copy of the following medical records:

- ° Complete Medical Records (Additional Fees may apply)
- ° Biopsy Reports
- ° Lab Reports
- ° Consultation Reports
- ° Surgical Procedures

The information authorized for release may include records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I also understand that the psychiatric (Including depression) and/or chemical dependency conditions and/or medications for these conditions may be contained in my medical records and cannot be separated during the process of complying with my request for such information. By this acknowledgement, I waive all rights and privileges allowed by law relating to Disclosure of Confidential Information, Defamation, and Invasion of Rights of Privacy. I understand that this authorization is subject to revocation by me at any time except the extent that the action has already been taken in reliance on it.

By signing this request, I do give my permission for mail or electronic transmittal for request for medical record request. Furthermore, I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed above.

Signature of Patient, Parent, or Legal Guardian

Relationship to Patient

Date Signed