AUTHORIZATION TO RELEASE MEDICAL RECORDS

DATE: _____

PATIENT NAME:_____ PREVIOUS NAME: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____ PHONE: _____

I AUTHORIZE MY PHYSICIAN: _____

___ TO PROVIDE SPECIFIC INFORMATION (Please List Exact Items Requested)

_____

_____

_____

___TO PROVIDE FULL DETAILS OF MY MEDICAL HISTORY AND TREATMENT

REASON FOR DISCLOSURE: _____

PERSONS TO WHOM INFORMATION MAY BE DISCLOSED TO:

NAME: _____

ADDRESS:_____

_____

PHONE: _____ FAX: _____

EMAIL: _____

I understand that my records are protected under federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise permitted by the regulations. I understand that when necessary, portions of my medical records may be faxed or mailed via HIPAA-compliant email.

I understand that I have the right to terminate or revoke this authorization, at any time except to the extent that the action has already been taken relative to it, by submitting a written revocation to Bloom Dermatology.

I understand the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnoses, testing or treatment. By signing here I authorize the release of this specific information.

_____

Signature of patient or patient's authorized representative **Date Signed**

I understand that I do not have to sign this form to receive treatment from Bloom Dermatology.

_____

Signature of patient or patient's authorized representative **Date Signed**

_____

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE SIGNED.