Dermatology, Laser & Vein Specialists OF THE CAROLINAS

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Information:

Name: _____ **Date of Birth:**_____

Dermatology, Laser & Vein Specialists of the Carolinas is authorized to release protected health information about the above named patient to the person(s) listed below and in the methods selected.

Individual(s) to Receive Information: (e.g.- spouse or family members) *list anyone that you approve to receive information		**Check Information Allowed:** Financial	Medical
1._____	Phone #:_____	_____	_____
2. _____	Phone #:_____	_____	_____
3._____	Phone #:_____	_____	_____

Appointment Reminders: please check the type you would like to receive from our office

Telephone/Voicemail: _____ Text Message: _____

At my request the following items may also be released: please check all that apply

☐ Entire Record ☐ Financial Record ☐ Office Visit Notes ☐ Biopsy Reports

☐ Operative Reports ☐ Allergies ☐ Consultation Reports ☐ Lab Reports

Email Communication:

I understand that if email correspondence is not sent in an encrypted manner there is a risk that it could be accessed inappropriately. I still elect to receive email communication. **Initial**: _____

Patient Rights:

I have the right to revoke this authorization at any time.
I may inspect or copy the protected health information to be disclosed as described in this document.
Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
I understand that released information may include a communicable disease diagnosis such as HIV.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

_____ _____

Signature of Patient or Patient Representative Date

_____

Description of Patient Representative's Authority* (if applicable) ***PLEASE ATTACH NECESSARY DOCUMENTATION**