Alexandria ASSOCIATES IN DERMATOLOGY

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT INFORMATION

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, ZIP: _____ Phone: _____

At my request, _____ may release the following information
(Name of the entity)

☐ Entire record ☐ Financial Records ☐ Marketing*

☐ On site record reviewed by the patient ☐ Office visit notes

☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released

☐ Diagnostic studies (list): ☐ Other as listed

COST:

Hard copy up to 50 pages…. $20
Over 50 pages….$35

* Financial compensation is received for this communication.

Entity or person who will receive this information:

Name: _____

Address: _____

City, State, ZIP: _____ Phone: _____

☐ Send the information electronically. Email Address: _____

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk that it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

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

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 may refuse to sign this authorization and that my treatment will not be conditional upon signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

Signature: _____ Date: _____