WINSTON SALEM DERMATOLOGY & SURGERY CENTER, PLLC

Authorization to Release Health Information to a Health Care Provider

Patient Name: _____ Date of Birth: _____
Please print full name

By signing this authorization, I authorize Winston Salem Dermatology & Surgery Center to use and/or disclose certain protected health information about me to or for the party or parties listed below.

The information to be used and/or disclosed is as follows:
€ My complete medical records € Progress Note € Consultation Note € Lab Results € Pathology Results €
Other:_____

Please release my protected health information identified above to:

_____
Name of Organization

_____
Address

_____
Phone Number Fax Number

This information for which I am authorizing disclosure will be used for the following purpose:
€ My personal use € Sharing with other healthcare providers € Workman's Compensation
€ Transfer care to another provider (**By authorizing the release of my complete medical record for care to be administered by another provider, I am acknowledging the transfer of my care to the above mentioned practice effective within 30 days)** € Other _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. My written revocation must be submitted to the Privacy Officer at Winston-Salem Dermatology & Surgery Center, 1400 Westgate Center Dr., Ste. 200, Winston-Salem, NC 27103.

This authorization will expire on _____. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

I understand that once the above information is disclosed, the recipient may redisclose it, and the federal privacy laws or regulations may not protect the information. I understand the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

_____ _____
Signature of patient or legal representative Date

_____ _____
If signed by legal representative, relationship to patient Date

_____ _____
Witness Signature Date