AUTHORIZATION for RELEASE of MEDICAL RECORDS

(For Use or Disclosure of Protected Health Information, or PHI)

Patient Name **Date of Birth** **Phone Number**

I AUTHORIZE THAT MY MEDICAL INFORMATION:

❑ ***Be RELEASED To:***

❑ ***Be OBTAINED From:***

Name of Provider / Facility / Individual / Organization

Address City State Zip

Phone Number Fax Number

SPECIFIC INFORMATION TO BE PROVIDED:

❑ Pathology Report(s) ❑ Chart / Progress Notes

❑ Lab Result(s) ❑ Other:

For the Time Period of: _____

THE REASON THIS INFORMATION IS NEEDED:

❑ Transfer of Care to Another Provider

❑ At the Request of Patient or Legal Representative

❑ Personal Use

❑ Other

By signing this authorization, I indicate that I understand that this release is effective for one (1) year from the date of execution; that I may revoke it at any time by providing notice in writing to the above-named party, except when action has already been taken to comply with my request; and that I hereby release Kalamazoo Dermatology from all legal responsibility or liability that may arise from the disclosure of the information set forth above relating to my records.

I also acknowledge that I am aware that it may take up to ten days for the records to be sent, and that any required fees must be paid in advance:

Patient / Responsible Party Signature Date

Witness Date

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