Authorization to Release Medical Records

Patient Information

Patient Name: _____ Patient Date of Birth:_____

Street Address: _____

City: _____ State: _____ ZIP code: _____

Entity to Release Medical Records

Name: _____

Phone: _____ Fax: _____

Email: _____

Street Address: _____

City: _____

State: _____ ZIP code: _____

Entity to Receive Medical Records

Name: _____

Phone: _____ Fax: _____

Email: _____

Street Address: _____

City: _____

State: _____ ZIP code: _____

Method of delivery: ▢ Physical copies ($6.50 fee may apply) ▢ Fax ▢ Email ▢ Verbal

Health Information to Be Released

Information to be released: ▢ Entire medical record (all information)

▢ Medical records between: from: _____ to: _____

▢ Other: _____

Reason for release: ▢ Treatment ▢ Personal use ▢ Legal ▢ Other: _____

Note: Medical records released as part of this authorization may contain references related to mental health, substance abuse, genetic testing, communicable disease, AIDS, and HIV medical conditions.

Authorization Expiration

Without my express revocation, the authorization will automatically expire:

▢ After one-time disclosure, if all needs are satisfied ▢ On _____ (mm/dd/yyyy)

▢ Upon death ▢ Other: _____

- I hereby voluntarily authorize Altamonte Dermatology to use or disclose my individually identifiable protected health information as described above for the purpose listed. I understand this authorization is voluntary and I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I have the right to revoke this authorization. To do so I understand I can submit my request in writing to Altamonte Dermatology. The authorization will stop further release of my protected health information on the date my valid revocation request is received.
- If the organization or person I have authorized to receive the protected health information is not a health plan or healthcare provider, the released information may no longer be protected by federal and state privacy regulations.
- I have the right to receive a copy of this authorization.
- Reasonable fees may be charged to cover the cost of copying and postage related to releasing this protected health information.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

This form must be scanned into the patient's medical record.
Under HIPAA with patients' written request, records must be provided within 30 days of a request.
Under House Bill 300 Texas Law with patients' written request, records must be provided within 15 days of a request.