Dermatology Associates of Rochester, PC

[ ] 100 White Spruce Blvd
Rochester NY 14623
Phone: 585-272-0700
Fax: 585-272-8356

[ ] 4 Coulter Road
Clifton Springs NY 14432
Phone: 315-462-1495
Fax: 315-462-2003

Patient authorization to disclose Protected Health Information

Patient Name ____ Date of Birth______________

Address ____ Phone # __________________

City/State/Zip ______________________________________

[ ] I authorize Dermatology Associates of Rochester to RELEASE information to:

Name of Provider ___________________________

Address ___________________________

City/State/Zip ___________________________

Phone ___________________________

Fax ___________________________

[ ] I authorize Dermatology Associates of Rochester to OBTAIN information from:

Name of Provider ___________________________

Address ___________________________

City/State/Zip ___________________________

Phone ___________________________

Fax ___________________________

Information or medical record to disclose:

- o Complete medical record
- o Biopsy report(s)
- o Lab report(s)
- o Surgical procedures
- o Other: ____

I understand that my right to healthcare treatment is not conditioned on this authorization. I may cancel this authorization at any time by submitting a written request to Dermatology Associates of Rochester, except where disclosure has already been made in reliance on my prior authorization. If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information above could be re-disclosed by the recipient and may no longer be protected by federal or state law. This authorization request remains in effect for 30 days from the date of my signature below. I further realize that there may be a copying fee of $0.75 per page for transferring my medical records. Under New York State Law Section 17, charging for copies of medical records is permissible.

X____ ___________________

Signature of patient/legal guardian **Date of signature**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

____ _________________________

Name of patient representative **Relationship to patient**

For office use only:

Staff initials _______