100 White Spruce Boulevard
Rochester, NY 14623
Phone: 585.272.0700
Fax: 585-272-8356

Patient Authorization to Disclose Protected Health Information

Patient Name: ____

Address: ____

Phone: ______________________________ Date of Birth: ____________________

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

Name of Provider: ____

Address: ____

Phone:______________________________ Fax: ______________________________

Information to disclose: **[ ] COMPLETE MEDICAL RECORD**
[ ] Biopsy Report(s)
[ ] Lab Report(s)
[ ] Surgical procedure(s)
[ ] 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 with my previous authorization. If covered by privacy regulations, the information above may 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 NY State Law, Section 17, charging for medical records is permissible. Lastly, I understand that releasing and/or obtaining my records may take up to 30 days to complete.

____ ____________________
Signature of patient or legal representative Date

____ ____________________
Name of legal representative Relationship to patient

VR 7/31/2018

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Office use only: Date Rec'd: ____________________ Date Sent: ____________________ Staff Initials: ____________________