Paladin Dermatology

Release of Information

Authorization to Release or Obtain Confidential Health Care Information

		Information to be Released To ☐ or Obtained From ☐
(Print Patient's Full Name)	(Date of Birth) M/D/Y	Name
(Street Address)	Phone (Home or Cell)	Street Address
(City, State, Zip Code)	Phone (Work)	City, State, Zip Code
(Email address)		Fax (Request faxed for Continuity of Care Only)

I, ___________________________________ hereby authorize ___________________________________ _______________ to release ☐ or obtain ☐ the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include physical and mental illness, alcohol/drug abuse, genetics and /or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient psycotherapy notes.

Specific Information to be Disclosed:

☐ Medical Record from (insert Date) __________________________ to (insert date) __________________________

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers

☐ Other: ____

Reason for Release of Information

☐ Treatment / Continuing Medical Care
☐ Personal Use
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other (Specify): ____________________

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving a written notice to the medical office. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

Paladin Dermatology

Release of Information

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form

- If the patient is 18 years of age or older, the patient must sign this form.
- If the patient is 18 years or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship.

  ☐ Legal Guardian ☐ Health Care Power of Attorney

- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under the stat or federal law. Please indicate your relationship.

  ☐ Parent ☐ Legal Guardian

Signature (Required)		**Date Signed (Required) (M/D/Y)**	
Printed Name of Person Signing			
Mailing Address			
City	**State**	**Zip Code**	**Phone**

Obtaining Your Medical Records

You have the right of access to inspect and obtain a copy of your confidential health care information. The law requires a signed authorization form which contains certain criteria included on this form. The form must be fully completed before any medical information can be released.

Getting Your Records

Your request will be completed within 15 days of receipt. You will be notified when your records are ready or if the records cannot be processed within this timeframe. If you would like to pick up your records, or have the records mailed to the address listed on the authorization form, please indicate this on the authorization form. Records will be faxed only for continuity of care purposes.

Costs

$0.50 per page up to page 50
$0.25 per page, page 51 and up

How to Release Your Medical Records

Complete this authorization form in its entirety and hand-deliver, mail or fax to the following address:

Paladin Dermatology
Release of Information Services
44 A Medical Park Blvd.; Petersburg, VA 23805
Office: (804) 835-6777; Fax: (804) 835-5103