Brevard Skin & Cancer Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____

Address:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The type of information to be used or disclosed: (check all boxes that apply)

_____history and physical _____office notes _____ pathology reports
_____lab results _____operative reports _____entire medical records

3. Please specify the dates of service you are requesting the above information **FROM_____TO_____**

4. I understand the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I authorize Brevard Skin and Cancer Center to disclose the above information to the individual or organization identified below.

Name:_____ Phone:_____ Fax:_____

Address_____

6. This information for which I am authorizing disclosure will be used for the following purpose:

_____personal records are reproduced at a $1.00 per page. _____Legal purpose at a $1.00 per page.
_____continued care/Dr. _____other (specify) _____

7. Information to be disclosed in manner of my (the patient's) choosing:
_____ Paper (faxed, mailed) _____ Electronic (through our computer system to designated destination)
_____ Electronic Copy (CD/Flash-drive, encrypted for your safety)

8. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Brevard Skin and Cancer Center where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in six months from the date signed. (All records require 72 hours to reproduce.)

Signature of Patient or Legal Representative: _____Date: _____

FOR OFFICE USE ONLY

Verified identity using: [ ] Driver's License [ ] Work/Gov't ID
[ ] Company/Agency letter [ ] Other: _____

Verified authority to request information using:
[ ] Patient's current authorization [ ] Written authority on agency letterhead
[ ] Judicial subpoena/court document [ ] Other: _____

Number of patient records included in this request: _____.

Request entered in logbook on _____.

[ ] Request approved by _____ on _____.

[ ] Information sent to recipient via _____ on _____.