MID-CHARLOTTE DERMATOLOGY
SOUTHEAST VULVAR CLINIC
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

A COPY OF THIS FORM MAY BE USED IN THE SAME MANNER AS THE ORIGINAL

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI) AS DESCRIBED BELOW.

I UNDERSTAND THAT IF THE PERSON OR ENTITY AUTHORIZED TO RECEIVE THIS INFORMATION IS NOT A HEALTH CARE PROVIDER OR HEALTH PLAN COVERED BY FEDERAL REGULATIONS, SUCH AS HIPAA, THE INFORMATION DESCRIBED BELOW MAY BE RE-DISCLOSED BY SUCH PERSON OR ENTITY AND MAY NO LONGER BE PROTECTED BY REGULATIONS.

I UNDERSTAND THAT I WILL NOT BE DENIED TREATMENT FOR REFUSING TO SIGN THIS FORM.

PATIENT INFORMATION		
Last name: First name: MI:	Date of Birth:	Social Security #:
Street Address:	City: State: Zip:	Phone #:

INFORMATION RELEASED TO/FROM	
Name/Company Name: **DR. LIBBY EDWARDS/SHARON SWARTZ, PA-C/ MID-CHARLOTTE DERMATOLOGY, SOUTHEAST VULVAR CLINIC**	
Street Address: **6406 CARMEL ROAD, UNIT 309**	City, State, and Zip: **CHARLOTTE, NC 28226**
Phone #: **704-367-9777**	Fax #: **704-367-0504**

INFORMATION RELEASED TO/FROM	
Name/Company Name:	
Street Address:	City, State and Zip:
Phone #:	Fax #:

RECORDS TO RELEASE		**PURPOSE FOR RELEASE OF RECORDS**	
ENTIRE MEDICAL RECORD		**CONTINUATION OF CARE**	
OFFICE NOTES		**LEGAL INVESTIGATION**	
DIAGNOSES		**WORKER'S COMPENSATION**	
LAB AND PATHOLOGY REPORTS		**STAFF/PHYSICIAN ISSUES**	
DATES OF TREATMENT		**DISABILITY DETERMINATION**	
PROGRESS NOTES		**PERSONAL (PATIENT REQUEST)**	
OTHER		**OTHER**	

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF THE SIGNATURE BELOW.

I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO MID-CHARLOTTE DERMATOLOGY/SOUTHEAST VULVAR CLINIC, BUT THAT REVOKING THIS AUTHORIZATION WILL NOT AFFECT DISCLOSURES MADE OR ACTIONS TAKEN BEFORE THE REVOCATION IS RECEIVED.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE: **DATE:**

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NAME AND RELATIONSHIP OF AUTHORIZED REPRESENTATIVE:

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