Dermatology Consultants, P.C.
General, Surgical, & Cosmetic Dermatology

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ______________________________________ **Patient ID:** __________________
Address: ____ **Date of Birth:** __________________
City / State / Zip ______________________________________ **Mobile Phone:** __________________

I authorize the release of medical information as indicated below:

☐ I would like records to be published to my **Secure Patient Portal**. **(This is our preferred method!)**
Please ask for assistance with access to the Patient Portal if you have not set up a login.
☐ I would like records sent to my Physician's Secure Direct Address*: _____________________________________
** Please note, this is not a regular email address. This is an encrypted address for physician to physician communication.*
☐ I would like records sent via email** at ___________________________________
*** Please note, sending information via email is unencrypted and could expose your Protect Health Information (PHI) to to security risks. The practice does take all measures possible to transmit any PHI in a secure format.* ***I understand that in requesting information to be sent in this format, that I am releasing Dermatology Consultants, P.C. from all liability and security risks associated with sending any PHI via email.***
☐ I would like to pick up a copy of my records in the following format: ☐ Hardcopy ☐ Flash Drive
☐ I would like records faxed to: *(please indicate fax #)* ________________________________
☐ I would like records mailed to the address listed below in the following format: ☐ Hardcopy ☐ Flash Drive

Business: ___________________________________ **Name/Provider:** ______________________________
Address: ___________________________________ **City, State, ZIP:** ______________________________

What to Release: Please choose the records you would like released: (Specify Dates below)

☐ Outpatient Visit Notes *Dates:*_______________ ☐ All medical records
☐ Pathology Report(s) *Dates:*_______________ ☐ Photos *Dates:*___________________________
☐ Laboratory reports *Dates:*_______________ ☐ Other Specify _____________________________________

NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV tests ☐ Yes ☐ No/NA
The diagnosis or treatment of drug and/or alcohol abuse ☐ Yes ☐ No/NA
The treatment and/or consultation for mental health or Psychiatric disorders ☐ Yes ☐ No/NA

Purpose of the release: *(Please indicate the reason for this release)*

☐ For another physician of care
☐ Personal use
☐ Follow-up related to an injury
☐ Use in a lawsuit
☐ To obtain disability
☐ Worker's care
☐ Armed forces requirement
☐ Other ______________________________

Expiration date: (This authorization will expire in sixty days unless otherwise indicated below.)

☐ Please change the expiration date to last for ____________days.

2045 Peachtree Rd NE, Suite 200 · Atlanta, Georgia 30309 · (404) 351-7546 · Fax: (404) 351-2993
4800 Olde Towne Pkwy, Suite 250 · Marietta, Georgia 30068 · (770) 971-3376 · Fax: (770) 578-8567
4151 Hospital Drive · Covington, Georgia 30014 · (770) 784-0343 · Fax: (678) 729-9769

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I understand that electronic media pose certain risks to the privacy and security of my protected health information that may be beyond the control of I agree to assume such risks personally, and to hold Dermatology Consultants harmless in the event my protected health information is breached or compromised as a result of my directing and authorizing Dermatology Consultants to transmit or deliver such information electronically.

I understand this Authorization can be revoked at any time according the Dermatology Consultants' privacy practices. This request must be made in writing and sent to the same place as the original request. I understand that a revocation is not effective to the extent that Dermatology Consultants has relied on this authorization for the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Dermatology Consultants and may potentially be re-disclosed by the party who received these records. Dermatology Consultants, its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Have an electronic copy of my medical records, or a portion thereof, transmitted to any third party or person I designate.
- Refuse to sign this Authorization.

The use or disclosure requested under this Authorization will result in direct or indirect remuneration to the Dermatology Consultants from a third party, if applicable.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

____ ________________________

Signature of the patient Date

FOR OFFICE USE ONLY

Received by:	
Date received:	
Action(s) taken:	
PHI Disclosed to:	
Disclosure media:	☐Hardcopy ☐Memory Stick ☐CD-ROM
Discloser signature:	

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