

DERMATOLOGY ASSOCIATES OF YORK, INC

.....
205 Saint Charles Way
York, PA 17402
Phone: (717) 741-4666 Fax: (717) 741-9649

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Chart# _____

Address _____
Street City State Zip

Birthdate _____ Social Security # _____ Phone _____

I hereby request and authorize the following institution to release my information:

Name _____ Phone _____

Address _____
Street City State Zip

Release to:

Name _____ Phone _____

Address _____
Street City State Zip

This information has been disclosed to you from records whose confidentiality is protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

What Information to Send:

_____ A complete copy of the above named patient's medical records, including all records relating to mental health, drug or alcohol related conditions, or HIV status if applicable.

_____ Specifically, send only:

Pathology Report (s) from _____

Chart notes from _____

Other (please specify) _____

What is the Purpose of Disclosure:

Change of Insurance (Please provide name of new insurance: _____)

Disability Application

Legal Request

Moving Out of the Area

Referral Appointment

Other (please specify) _____

Please note that the initial release to another physician is complimentary. Subsequent copies to physicians will be sent at the same rate as all other medical record copies. This payment will be due prior to records being copied.

I understand that this authorization can be revoked at any time except to the extent that you have relied on the authorization. To revoke this authorization, I must notify Dermatology Associates of York, in writing.

A revocation will not impact any action taken prior to our receipt of the revocation in reliance on this authorization.

I understand that this authorization will expire in 60 days unless otherwise specified _____

Dermatology Associates, its employees, offices and contracting physicians are released from liability for the release of the above information to the extent indicated and authorized herein. I understand that there may be a charge for the copying of these records that is payable prior to the records being released.

Signature of Patient/Guardian or Personal Representative

Date

Print Personal Representative's Name

Relationship to Patient

Signature of Staff Person Obtaining Authorization

Date