

Central Carolina Dermatology Clinic, Inc.

Authorization to Release Health Information to a Health Care Provider

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

Name & address of Covered Entity authorized to release information:

Forward information to:

The information below will be used for patient care. (Description of Protected Health Information needed)

This authorization shall be in effect until the information has been forwarded as requested.

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to _____

_____.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)
