MOD DERMATOLOGY

Authorization for Release of Health Information

Patient Name: _____ Date of Birth. _____

Address: _____ Phone # _____

I hereby authorize MOD Dermatology to disclose my health information as follows:

☐ Release information from MOD Dermatology to recipient(s):

☐ Release information from recipient(s) to MOD Dermatology:

Name: _____

Address: _____

Phone: _____ Fax: _____

Information to be disclosed: (check all that apply)

☐ Pathology/Lab reports ☐ Progress notes

☐ Imaging Reports ☐ Complete Records

Date of service or time period of records to be disclosed: _____

(State time period or "all")

Please release records via:

☐ Fax to _____ ☐ Email to _____

☐ Mail to _____

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at MOD Dermatology, PC.
2. Medical information to be disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by State or federal law.
3. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to MOD Dermatology. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____

Signature of patient or patient's personal representative Date

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