DERMATOLOGY ASSOCIATES OF COASTAL CAROLINA

2115 NEUSE BLVD NEW BERN, NC 28560
(P) 252-633-4461 (F) 252-633-6016

Authorization for Release of Medical Information

(Expires upon one-time release)

Chart # _____

Patient Name _____ DOB _____ Daytime Phone # _____

Address _____ City _____ State _____ Zip Code _____

I authorize _____ to release the selected information below to _____.

Information Released From:

_____
Name

_____
Address City State Zip

_____
Phone # Fax #

Information Released To:

_____
Name

_____
Address City State Zip

_____
Phone # Fax#

Dates of Services Requested: _____ to _____

Information to Release:

- ○ Pathology Reports
- ○ Operative Reports
- ○ Clinical Notes
- ○ Other: _____
- ○ Lab Reports
- ○ Billing Summary

I would like to receive my records by (check which applies):

- ○ Mail – if address is different than above please notate the correct address
- ○ In office pick up – **check** the office below where you would like to pick up your records
  - ○ New Bern
  - ○ Morehead City
  - ○ Kinston
  - ○ Jacksonville

- **If over 25 pages please mail records to the address above & NO discs**
- Patients: If requesting more than 5 office visits there will be a $25 Medical Records processing fee

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 re-disclosure 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 Dermatology Associates of Coastal Carolina. **You may not sign this document if you are not the patient, guardian, of legal representative (Power of Attorney paperwork must be documented).**

_____ _____

Signature of Patient or Legal Guardian/Representative Date