OAKVIEW
DERMATOLOGY

Authorization to Release Medical Information

1. I AUTHORIZE:

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

_____
Phone Fax

2. TO RELEASE TO:

Oakview Dermatology
Name of receiving person/organization

2111 East State Street
Street Address

Athens Ohio 45701
City State Zip Code

(740) 566-4621 (740) 566-4622
Phone Fax

3. **INFORMATION TO BE RELEASED:** (Check all applicable)
☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other:_____

4. **RECORDS FROM THE TIME PERIOD:** / / through / /_____

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)
☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Workers' Compensation Claim ☐ Other: _____

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this authorization in writing and provide any exceptions to the right to revoke at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization upon request.

9. I am not required to sign this authorization. Oakview Dermatology does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. If I do not sign this authorization, Oakview Dermatology will not disclose My Health Information as requested.

10. I understand that once My Health Information is disclosed as requested in this authorization My Health Information may no longer be protected by federal and state privacy laws and potentially may be re-disclosed by the person who is receiving my information.

11. By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, and drug and alcohol abuse.

Print Patient's Name: _____ Date: _____

Patient's Signature: _____

Date of Birth: _____ Home Phone: _____