**Medical Records Release Authorization Form**

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 Patient Name DOB

Where would you like your records to go?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Fax

For Records **FROM** Carolina Dermatology

(Choose ONE of the following):

□ Faxed to Medical Office/sent via e-mail – No Fee

□ Picked up in person at Carolina Dermatology (M-Th: 8am-5pm; F: 8am-1pm)

* I understand that there is a clerical fee of $15
* I understand the first 5 pages are free of charge
* I understand that after 5 pages I will be charged $0.65 per page, up to 30 pages, and $0.50 each page thereafter. I have completed a medical records payment for this purpose.

□ Mailed to the address above

* I understand that there is a clerical fee of $15
* I understand that after 5 pages I will be charged $0.65 per page, up to 30 pages, and $0.50 each page thereafter, plus postage. I have completed a medical records payment for this purpose.
* I understand the above fees will be waived if the recipient is a medical doctor’s office or insurance company.

I authorize Carolina Dermatology to release/receive my medical records as indicated above. **Please allow 72 hours for processing.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Carolina Dermatology Representative Date

For your protection and privacy, it is our policy not to release any information regarding your medical history to anyone without your authorization. This authorization remains in effect unless changed or revoked in writing.
**All required information must be filled out to avoid any delays receiving and/or sending Medical Records.**