ESSENTIAL
dermatology
Austin Newsome, MD, FAAD

Authorization for Release of Protected Health Information (PHI)

PATIENT NAME DATE OF BIRTH PHONE NUMBER

☐ To or ☐ From: **Essential Dermatology**
101 Rolesville Center Rd, Suite 125
Rolesville, NC 27517
Phone: (919) 205-4473 fax:(919) 366-5998

☐ To or ☐ From: ☐ Patient

☐ Other: Provider Name_____
Clinic/Company Name: _____
Address: _____
Phone: _____Fax:_____

☐ All Pathology, labs, imaging, visit notes

☐ Records related to: ☐ Pathology/labs/imaging ☐ Other: _____

☐ Visit notes from dates _____to _____

☐ Pick-up Records

☐ Fax Records to Patient: #_____

☐ Mail Records to:

_____

ADDRESS CITY STATE ZIP

If you **do not** wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric, **please initial here** _
Unless initialed here this information is deemed permissible to release.
This authorization will expire 1 year from the date signed

Notice to Patient:
When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy Officer at Mountain Pine Dermatology, PLLC. You do not have to sign this authorization and your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. Photocopies, facsimile or scan of this Authorization shall be considered to be the same as a signed original.

SIGNATURE of Patient or Personal Representative*_____ **DATE** _____

*Personal Representative includes: parent of any minor patient under 18 years of age, legal guardian, power of attorney etc.