Plymouth Dermatology ASSOCIATES

Mail or Fax Release Form to:
345 Court Street, Suite 201
Plymouth, MA 02360
Fax: 508-747-2001

Authorization for Release of Protected Or Privileged Health Information

Please print all information clearly in order to process your request in a timely manner.

A. Patient Information

Patient Name: _____ Date of Birth: _____

Address: Street: _____Apt# _____

City: _____State: _____ Zip Code: _____

Preferred Phone #: _____

B. Permission to share: I give my permission to share my protected health information.

Records from:

Practice Name: Plymouth Dermatology Associates

Provider Name: _____
(Optional)

Purpose: (check all that apply)

- ☐ Medical Care
- ☐ Insurance
- ☐ Legal
- ☐ Personal
- ☐ School
- ☐ Other (please specify)

Send records to (Enter where you would like Plymouth Dermatology Associates to send your information to):

☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below:

Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____

Send by:

- ☐ Fax (provide fax number)
- ☐ Paper Copy via Mail

C. Information to be released (please check all that apply, and specify dates if applicable):

- ☐ Date(s) of Medical Records (e.g. History & Physical, Operative Report, Consults, Photos, Tests Reports _____
- ☐ Date(s) of Clinic Visit Notes_____
- ☐ Date(s) of Lab Reports_____
- ☐ Date(s) of Pathology Reports_____
- ☐ Date(s) of Billing Records_____
- ☐ Other (please specify) _____
  _____

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D. Please check Yes to indicate if you give permission to release the following information if present in your record:

☐ Yes HIV Test Results (Patient authorization required for each release requests.)
Specify dates_____

☐ Yes Genetic Screening test results
Specify type of test_____

E. I understand and agree that:

- PDA cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PDA may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility or benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the office except:
  - If PDA has already processed the request (for example, once information is released, it will not be retrieved)
  - If I signed this authorization as a condition of obtaining insurance. Other laws may provide the insurer with a right to contest a claim under the policy or the policy itself.
- This authorization will automatically expire 6 months from the date signed unless otherwise specified
- I understand that if PDA maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- It may take up to 14 business days to process this request
- My questions about this authorization form have been answered

Patients Signature: _____ **Date:** _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ Relationship of representative to patient: _____