

**Record Release of Patient Information from Advanced
Dermatology Associates, Ltd.**

Patient's Name: _____
(Print name)

Patient's Date of Birth: _____

Patient's Address: _____

Patient's Social Security/Account Number: _____

The above identified patient is requesting the following information be made available to: _____

Address to send information: _____

Information and date of services to be released: _____

I understand that the individual I authorize to receive my medical information may not need to follow the stringent privacy standards that Advanced Dermatology Associates, Ltd. follows set by the HIPAA (Health Insurance Portability and Accountability Act) rules and regulations. I understand this authorization may be revoked by me, through written notification, at any time, except for any action, which has already been taken. The authorization shall remain in effect and valid for **1 year from date signed.**

Signature of Patient: _____ Date: _____

Signature of Patient Representative/POA: _____

Date: _____

Medical Records shall be processed within 7 days of the date requested.

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Name and title of person who released records:

Method of how the information was transferred, please choose one:

Mailed to: _____

circle one: First Class Mail Certified Mail/return receipt requested

Faxed to: _____ date: _____

(fax number)

Picked up by: _____ date: _____

(name)

By courier: _____ date: _____

(name)

Verification of courier performed: circle one: Yes No