



Authorization to Review or Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____ Phone _____

City, State, Zip _____

I authorize the practice below to release my health information:

CARY SKIN CENTER, PA

200 Wellesley Trade Lane

Cary, NC 27519

Please forward/release my health information to:

I request a copy or summary of the following medical records:

- | | |
|--|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Office Visit Note(s) |
| <input type="checkbox"/> Pathology Report(s) / Lab Report(s) | <input type="checkbox"/> Operative Report(s) |
| <input type="checkbox"/> Other as Listed: | <input type="checkbox"/> Information necessary to file cancer policy |

For dates of service from _____ to _____.

NOTE: Patient requests for medical records will incur a \$15.00 fee payable prior to release of records.

This authorization shall be in effect until the information has been forwarded as requested.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (attach necessary documentation)

For Office Use Only

- | | | |
|---|------------|----------------|
| <input type="checkbox"/> Records Faxed | Date _____ | Initials _____ |
| <input type="checkbox"/> Records Mailed | Date _____ | Initials _____ |
| <input type="checkbox"/> Records Emailed | Date _____ | Initials _____ |
| <input type="checkbox"/> Records Handed to Pt/Personal Representative | Date _____ | Initials _____ |