General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information

Patient Name: _____
Address: _____
Phone: _____
SSN: _____
Date of Birth: _____

I authorize the custodian of records of: _____ or other person/entity (specifically describe) _____ to disclose/release the following information

* (check all applicable):

☐ All records ☐ Laboratory/pathology records ☐ X-ray/radiology records ☐ Billing records
☐ Abstract/Summary ☐ Pharmacy/prescription records ☐ Other (describe specifically)

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to:

Name: _____ Name: _____
Address: _____ Address: _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

The information may be used/disclosed for each of the following purposes:

☐ At my request (only the patient can check this box)
☐ For my health care
☐ For payment/insurance
☐ For employment purposes
☐ Other:

This authorization shall expire no later than: ___/___/___ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature for medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's representative) Date

_____ _____
Printed name of patient representative Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to Laser + Skin Institute, 417 Main Street, Chatham, NJ 07928 Attn: Privacy Liaison.
A copy of this signed authorization must be given to the individual.