Authorization for the Release of Medical Record Information from or to Anne Arundel Dermatology, P.A.

Patient Full Name (If name has changed, please specify.)	Date of Birth
Street Address	City/State/Zip
Home Phone	Cell Phone

The above patient or his/her or her parent/legal guardian authorizes any Anne Arundel Dermatology, P.A., practice locations, to request or to make a disclosure of medical record information as follows:

Disclosed By: □AAD or ( ):	Disclosed To: □AAD or ( ):
Name – (e.g. Health Facility, Physician Practice…)	Name – (e.g. AAD Site, Insurance Company, Lawyer, Physician, Patient….)
Address	Address
City State Zip Code	City State Zip Code

Type of Information to Disclose: (Check all that apply)	The Purpose of this Disclosure is: (Check all that apply)
□ Entire Record □ Visit of _____(date) □ Pathology Results only □ Blood Test Results only □ Culture Test Results only □ Billing information only	□ Change of Insurance or Physician □ Continuation of Care □ Referral □ Personal Records □ Other: _____ □ **Check if you would like records mailed** □ **Check if you would like records faxed** **FAX NUMBER: _____**

Restrictions: Only medical records originated through Anne Arundel Dermatology will be copied and disclosed unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date of this authorization unless other dates are specified.

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office and/or Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy. This authorization will expire on the following date or condition:_____. Unless otherwise noted, this authorization will expire one year from the date of my signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules once redisclosed. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure from the Anne Arundel Dermatology Office.

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I understand copy fees may apply.

Signature of Patient	Date
Signature of Parent/Guardian or Authorized Representative	Date
Printed Name of Parent, Guardian or Authorized Representative	Relationship to Patient (Representatives: Attach proof of such status)
Address of Authorized Representative or Guardian	Telephone Number