AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name _____ Date of Birth _____

Home Phone _____ Cell Phone _____

Address_____ City/State/Zip_____

Email Address: _____

A) I hereby authorize records FROM:

Treiber Dermatology Associates

175 Purchase Street

Rye, NY, 10580

Phone: 914-967-2153 Fax: 914-967-0453

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone:_____FAX:_____

C) For the purpose of:

____ Change of Insurance

____ Self/Personal Copy

____ Continuity of Care

____ Relocating

Date Range_____to_____

☐ Physician Office Notes ☐ Cardiology/EKG Reports ☐ Operative/Procedure Reports

☐ Immunizations ☐ Lab/Path Reports ☐ Radiology/XRay/MRI Reports

☐ Other _____ ☐ Minimum Necessary

Include (Indicate by Initialing below): If not initialed information will not be released.

I understand the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental or behavioral health, and treatment for alcohol and drug use.

___ STDs ____ Alcohol/Drug Treatment ___ HIV/AIDS Related Information

____ Mental Health Treatment ___ Genetic Testing

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 any disclosure of information carries withit the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If Ihave questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that I have a right to 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 Medical Records Department. 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 the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

This authorization will expire one year from the above date unless I specify an expiration date: _____

(Expiration date of authorization)

_____ _____

(Signature of Patient/Parent/Guardian or Authorized Representative) (Date)

***PLEASE READ**

Fee Information: We reserve the right to charge the medical record stated fee structure as set forth in the NYS Article 18 Public Health Law. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy.