Medical Records Release Authorization

Rencic Dermatology
1102 Baltimore Pike, Suite 202
Glen Mills, PA 19342
Phone: 610.558.1446 Fax: 610.486.3015

Patient Legal Name: _____ **Date of Birth:** _____

I authorize **Rencic Dermatology** to: ( ) Release information to or ( ) Obtain records from
the following organization/individual/business (include fax/phone/address if available):
_____
_____

I grant permission to disclose the following medical records:

( ) Office Notes All/ Dates: _____
( ) Lab Test Results All / Date(s): _____
( ) Pathology Slides Pathology #/Dates: _____
( ) Pathology Reports Pathology Date: _____
( ) Complete Medical Records
( ) Other (please specify): _____

My Authorization (choose one):

( ) Allows for the disclosure of all applicable medical records, including but not be limited to, confidential information such as HIV test results, Mental Health Treatment, Lab Reports, Alcohol and Drug Therapy, Clinical Notes for Providers, X-Ray reports.

( ) Allows for the disclosure of applicable medical records, except for the disclosure of confidential information such as (choose all that apply):
( ) HIV Results ( ) Mental Health treatment ( ) Lab Reports ( ) Alcohol/Drug Therapy
( ) Clinical ( ) Imaging reports (such as x-ray, CT scans, MRI)
( ) Other (please specify): _____

My request is for the purpose of (select all that apply):
( ) Continuing Medical Care ( ) Self Use ( ) Insurance ( ) Attorney

I request that my records are prepared and disclosed in the following manner:
( ) Fax ( ) Mail ( ) Pickup/Call when ready ( ) email to :_____
(Please note that faxing/emailing/USPS mailing does not guarantee privacy once the records have left our facility by requested means).

This disclosure is a: ( ) one time disclosure ( ) continuing disclosure for 12 months
( ) other – specify: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation of this authorization and that such release shall not constitute a breach of my personal health information. I also understand that I have the right to review any prepared medical records prior to the disclosure requested.

Patient (legal) Signature: _____ Practice Staff: _____
Date: _____ Date: _____