

6800 Pittsford Palmyra Road, Suite 150, Fairport, NY 14450

Phone: 585-364-1177/585-364-1188

**Fax: 585-678-9654**

**Authorization for Release of Medical Information**

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Purpose for this request: \_\_\_\_ Healthcare \_\_\_\_ Insurance \_\_\_\_ Other

This Authorization allows Universal Dermatology, PLLC/Rochester Skin Lymphoma Medical Group, PLLC to:

 \_\_\_ Send copies of your record to (or discuss your information with) the provider/person/facility below

 OR

 \_\_\_Receive copies of your record from (or discuss your information with) the provider/person/facility below.

Name of Provider/Person/Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Records/Information Requested:**

\_\_\_\_ Inpatient: Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Outpatient: Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Clinic/doctor visit \_\_\_\_ Laboratory test results \_\_\_\_ Pathology reports \_\_\_Xray/imaging reports \_\_\_\_Emergency Dept records \_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my right to healthcare treatment is not conditioned on this authorization. I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed; ***except*** that records protected by Federal Confidentiality Rules 42CFR, Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations. Release of HIV-related information requires additional authorization. There may be a charge for the requested records. The medical records requested above may be faxed in cases of medical necessity.

**Signature of Patient or Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_**

**Relationship to Patient (*if Representative*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**