Columbus Skin Surgery Center inc.

Authorization to Release or Disclose Health Information

Patient Name: _____ Date of Birth: ____/____/____

I authorize the **Columbus Skin Surgery Center** to release my individual health information or medical record as described below.

The type of information to be released or disclosed is as follows:

For dates of service ___/___/___ to ___/___/___

☐ Medication Allergies ☐ Lab report(s) ☐ Consultation report(s)

☐ Clinic Note(s) ☐ Pathology Report(s) ☐ Radiology Report(s)

☐ Surgical Procedure(s) ☐ Complete Medical Record

☐ Other: _____

The information for which I am authorizing disclosure will be used for the following purpose:

☐ Other Health Care Providers

Provider Name: _____ Provider Phone: _____

Provider Address: _____ Fax: _____

_____

☐ My Personal Use

☐ Other: _____

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 Columbus Skin Surgery Center. 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.

This authorization will expire on ___/___/___. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

_____ ___/___/___

Patient Signature Date

_____ ___/___/___

Witness Signature (Practice Representative) Date