

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT INFORMATION Patient Name (as it appears on Driver's License or Photo ID): Patient Date of Birth (MM/DD/YYYY): I request and authorize Epiphany Dermatology to release healthcare information of the patient named above to: Address: Phone Number: Fax Number: _____ PLEASE SEND COPIES OF THE FOLLOWING MEDICAL RECORDS (CHECK ALL THAT APPLY): Office Consult notes Pathology report(s) Lab report(s) **Entire Medical Records** Other: I UNDERSTAND THE FOLLOWING I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations. I understand that the healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may refuse to sign this authorization. **SIGNATURE** Patient / Guardian Signature: Date: Exp Date (One year from date of request):