NOVEM
DERMATOLOGY

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Patient's Name: _____
(First) (MI) (Last)

Date of Birth: _____ Phone: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

I authorize the following personal health information:

☐ Visit Notes ☐ Pathology Results ☐ Lab Results ☐ Radiology Results / Images ☐ Other: _____

to be: ☐ **Released** or ☐ **Obtained** by Novem Dermatology to/from:

Name of Person/ Facility: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone #: (_____) _____ **Fax #**: (_____) _____

This authorization covers medical care from: _____ to _____
(date) (date)

Special Records: I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information.

☐ **ACCEPT RELEASE OF SPECIAL RECORDS** or ☐ **DECLINE RELEASE OF SPECIAL RECORDS**

Purpose of requested information:

☐ Legal ☐ Personal ☐ Insurance ☐ Continuation of Care ☐ Social Security/ Disability ☐ Other _____

I understand that this authorization is valid for 180 days from the date of signature. I also understand that I may revoke this authorization in writing at any time and I must do so in writing except to the extent that action has already been made before the receipt of revocation. Additionally, I understand that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Florida State Board of Medicine. Under the Privacy Policy Guidelines, I understand that my authorization for records is not needed in certain situations such as certain situations required by law, records required for treatment, payment and other healthcare operations, and research where there is a limited data set. By signing this form I understand that I am authorizing Novem Dermatology to release information as described above.

Authorization to FAX Medical Records: ☐ Yes ☐ No

_____
Patient Name (print) Patient Signature Date

If minor patient

_____
Parent/Guardian Name (print) Parent/Guardian Signature Date