CAMDEN
DERMATOLOGY
& MOHS SURGERY

Authorization for Release of Medical Information

Patient:_____ DOB: _____ Date:_____

Address: _____ City/State/Zip:_____ Phone: (____)_____

I hereby authorize Camden Dermatology & Mohs Surgery, LLC to:

___ Send copies of my medical records (or discuss information with) the provider/person/facility below

OR

___ Receive copies of my medical records (or discuss your information with) the provider/person/facility below

Name of Provider/Person/Facility: _____

Address: _____

City/State/Zip: _____

Phone: (____)_____ Fax: (____)_____

Information to be disclosed:

_____Entire Medical Record as related to Dermatologic Care

(including as warranted: clinical office notes, outside dermatology records on file, clinical photos related to dermatologic conditions, Mohs surgery notes, Mohs letter summary, Mohs map)

_____Pathology/Lab Report(s), including outside pathology reports on file

_____Progress Notes

_____Operative Notes

_____Cosmetic Procedure Notes

_____ Labs for last _____ yr(s)

This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

The above records are requested to be sent via CD, fax other HIPPA secure digital transmission, however we do request that all clinical photos or Mohs letters be mailed with either color prints or with CD for maximum patient benefit.

This authorization may be canceled at any time by submitting a written request to Camden Dermatology & Mohs Surgery, LLC. I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature: _____Date: _____

Parent/Guardian signature required for minor (< 18 years old): _____ Date: _____

Relationship to patient: _____ Printed name of Authorized Representative: _____