AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Information:

Name of Patient:_____ Date of Birth:_____

Address:_____

City:_____ State: _____ Zip Code:_____ Phone Number:_____

At my request, Andrus & Associates, PA may release the following information:

- ☐ Entire Record
- ☐ Diagnostic Reports (ex. labs, pathology results)
- ☐ Financial Records
- ☐ Record for Dates _____ to _____
- ☐ Other as Listed:_____
- ☐ Office Visit Notes
- ☐ Marketing*
- ☐ On-site Review by Patient

*****Financial compensation is received for this communication.

Entity or person who will receive the information:

Andrus & Associates Dermatology, P.A.
3809 Computer Drive, Suite 200
Raleigh, NC 27609-6518
Phone: 919-782-3782
Fax: 919-782-3788

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis, such as HIV.

_____//_____
Signature of Patient or Patient Representative Date

_____
Description of Personal Representative's Authority (Attach necessary documentation)

Revised March 2017