COBB DERMATOLOGY & AESTHETICS

Record Release Form

Patient Name:_____ DOB:____/_____/_____ Phone:_____-_____-_____ Date:____/____/_____

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION: PLEASE CHOOSE AN OPTION BELOW

☐ I authorize the release of my health information **FROM** the following to Cobb Dermatology & Aesthetics, 2007 Tate Springs Rd. Lynchburg, VA 24501

_____ ___ Entire Record ___Lab Reports ___ Billing Statements
_____ ___ Surgery Reports ___Office Notes ___Hospital Reports
_____, _____ ____ ___Pathology Reports ___ Diagnostic Imaging ___Most Recent History
_____-_____-_____ (Phone) ___Medical Records Needed for Continuity of Care
_____-_____-_____ (Fax)

☐ I authorize the release of my health information from Cobb Dermatology & Aesthetics 2007 Tate Springs Rd. Lynchburg. VA 24501 **TO**

_____ ___ Entire Record ___Lab Reports ___ Billing Statements
_____ ___ Surgery Reports ___Office Notes ___Hospital Reports
_____, _____ ____ ___Pathology Reports ___ Diagnostic Imaging ___Most Recent History
_____-_____-_____ (Phone) ___Medical Records Needed for Continuity of Care
_____-_____-_____ (Fax)

☐ I request a copy of my health information from Cobb Dermatology & Aesthetics, at the cost of $5 for the first 10 pages and .25 cents per page thereafter.

☐ Cancer Policy

****The following MUST be initialed to be included in the use or disclosure of other health information****

____HIV/AIDS related health information and/or records ____Mental health information and/or records
____Genetic testing information and/or records ____Drug/alcohol diagnosis, treatment, and/or referral information

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This authorization shall be in effect until the information has been forwarded as requested.

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand the information disclosed as a result of this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by Federal or State law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule. I understand that I have the right to revoke this authorization by sending a written notification to the address below and that revocation is not effective if the information has already been disclosed but will be effective going forward. I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Cobb Dermatology & Aesthetics, 2007 Tate Springs Rd., Lynchburg, VA 24501.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print or Type Name of Patient or Legal Representative Description of Legal Representative's Authority

_____ _____
Parent Signature if Patient is Under 18 Printed Name of Parent