OAK CITY
DERMATOLOGY

Authorization for Disclosure of Health Information

I hereby authorize the disclosure of my identifiable health information by method of mail, fax or email. I understand that this authorization is voluntary. If the organization authorized to receive the information is not a health plan/health care provider, the released information may no longer be protected by federal privacy regulations. A photocopy/scanned copy of this form is valid as the original.

Patient Information:

Name: ______________________________________ Date of Birth: __________________

Authorizes (Requesting From):

Physician/Provider/Other:____

Ph #: ____________________________ Fax #: _____________________________

Disclose To (Sending To):

▢ Oak City Dermatology- Maryam Haque, MD Ph #: 919-283-1099 Fax #: 984-220-9248

Information Authorized To Be Released:

☒ Unlimited ▢ Other: ____

I understand that the following information may be released. Check if you do NOT want to disclose records related to:

▢ Alcohol/Drug Abuse ▢ HIV Status ▢ Genetic Testing ▢ Mental Health Disorders ▢ Disabilities

Information Requested To Be Released:

▢ Last office note ▢ Most recent labs ▢ Operative report ▢ Pathology Result ☒ FULL RECORD

Purpose of Disclosure:

☒ Continued Care ▢ Other:____

Expiration: *I understand that while this authorization is in effect, effective immediately and indefinitely, I may revoke this authorization at any time and for any reason by submitting a written revocation to the office.*

____ __________________

Signature of Patient/Legal Representative **Date**

If signed by a person other than the patient, complete the following:

▢ Individual is: Minor, Legally incompetent or incapacitate, Deceased

▢ Legal authority: Parent Legal guardian Power of attorney Executor of deceased

INTERNAL USE ONLY: Signature Verified Initials: ___________ Date:________