SNYDER DERMATOLOGY

Request for Medical Records

Name (Legal/Maiden/Other) _____
Address _____
City _____ State ____ Zip _____ phone # _____
Date of Birth _____ Last 4 of Social Security Number _____

Provider name _____
Provider / Organization: Who is authorized to release the information.
Address_____
City _____
State ____ Zip _____
Phone # _____ Fax # _____

Requestor name _____
Requestor: (Where do you want the records sent?)
Address_____
City _____
State ____ Zip _____
Phone # _____ Fax # _____

Information requested:

Service Dates _____
Entire Record _____ Lab/Radiology Report _____

Purpose of release: (Check all that apply- *Charges may apply)*
Continuation of care ___ Insurance Coverage ___ Legal ___ SSI/Disability ___
Personal Use ___ Other ___

Requested format:

Mail _____ Fax _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I authorize the release of the information listed below, which requires specific consent under federal law: (Check all that apply)
Substance Abuse _____ Mental Health Treatment _____ HIV/AIDS related information _____

Right to revocation.

I have a right to revoke this authorization in writing except to the extent that action has been taken in reliance on this authorization. Your provider must receive the revocation in writing and the written revocation must include:
a. Your name and address,
b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
c. Your desire to revoke this authorization, and
d. The date of the revocation, and your signature.
This authorization shall expire one year after original authorization. After this date/event, your provider can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ __ _____ __ _____
Signature of Patient or Authorized Representative Printed Name / Relationship to Patient Date