# Authorization to Release Medical Records

Patient Name:_____ Date of Birth:_____

Address:_____ Phone: _____

**AUTHORIZATION:** I authorize:

Name/Organization: _____ Address: _____

Phone: _____ Fax: _____

to release the above-named individual's protected health information to

**Novi Dermatology PLLC**
**44000 W 12 Mile Rd Suite 103**
**Novi, MI 48377**
**Phone 248-946-4787 Fax 248-716-5956**

**SPECIFIC INFORMATION TO BE DISCLOSED**

☐ I authorize the release of my Complete Patient File. These notes may contain information on general medical care including records relating to communicable diseases, HIV or AIDS.
Please check the box below if you wish to include any medical records we may have regarding:
- ☐ Mental health records
- ☐ Substance use / Drug abuse diagnoses and treatment

☐ I authorize the release of the following:
- ☐ All Dermatology Office Visit, Procedure, and Communication Notes
- ☐ All Pathology reports
- ☐ All Lab tests and Radiology Reports
- ☐ All Photographs in the chart

☐ Other (please specify): _____

**FORMAT**

I request that the party authorized to disclose the protected health information provide **a secure electronic copy of the requested protected health information** to Novi Dermatology, unless Novi Dermatology requests a different format or the party authorized does not utilize electronic medical records.

**PURPOSE:**

My medical records will be used by Novi Dermatology for treatment, payment, and health care operations purposes, or other purposes as I may direct.

By signing this authorization, I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules. I further understand that I may request a copy of this signed authorization.

**Patient Signature: _____Date: _____**

Alternative Consent Authority and Signature

Patient's Parent or Guardian: _____Relation: _____

Patient's Parent or Guardian Signature: _____Date: _____