Authorization for Release of Healthcare Information to Forest Dermatology, PA

Patient Name: _____
Date of Birth: _____

I hereby authorize the transfer of the following healthcare information **to**:

Forest Dermatology, PA
1119 Hendersonville Rd, Suite 200
Asheville, NC 28803

Phone 828 274 6003 Fax: 828 274 6004

From: _____
_____
_____
Phone:_____ Fax: _____

Please send the entire chart
- or -
Please send only specific sections as noted below:

- Pathology Reports
- Lab Reports
- Correspondence
- Operative Reports

Purpose of Disclosure:
- Continuing Patient Care
- Other

I understand that specific information to be released may include, but is not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I also understand this authorization is subject to revocation/withdrawal by me by way of writing to the custodian of medical records in your office, except to the extent action has already been taken to release this information. This authorization shall remain valid unless revoked but will expire one year after signing. I have a right to inspect a copy of the health information to be released. If I do not sign this authorization, Forest Dermatology, PA will not release my health information to the requested medical office. Notice is given that law prohibits the re-disclosure of any health information regarding drug and/or alcohol use, HIV/AIDS and mental health treatment.

_____ _____
Signature of patient Date Signature of parent/guardian Date

_____ _____
Witness Date Relationship to patient Date