WACCAMAW DERMATOLOGY
Skin Cancer Institute

Phone: (843) 449-0453 Fax: (843) 449-9531
www.waccamawdermatology.com

Authorization to Release Medical Information

Patient Name: ____ Date of Birth: _______________________

Address:____

____

I AUTHORIZE THAT MY MEDICAL RECORDS BE SENT TO:

Circle One: TO or FROM	Circle One: TO or FROM
Waccamaw Dermatology	To: _______________________________________
917 Medical Circle	Fax: _______________________________________
Myrtle Beach, SC 29576	Phone: ____________________________________

Specific Information to Release:

( ) All Records	( ) Immunization Records	( ) Consultation Records
( ) X-Ray Reports	( ) Laboratory Reports	( ) Clinic Notes
( ) Itemized Bill	( ) Pathology Reports	

( ) Other: ____

I understand that in order to process this request for medical records on a timely basis, the entity(ies) may use a contracted medical records copying service. I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization. I also understand that this consent will expire 1 year after the dates of signature or automatically when the records requested on this authorization have been released. I understand that the information released may be released by the recipient and may no longer be protected by HIPAA.

SPECIAL AUTHORIZATION: If you are authorizing the above entity(ies) to release information related to testing, diagnosis, and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.

_________ My evaluation, testing, diagnosis, or treatment for alcoholism and/or drug abuse or dependence may be relayed to the recipient on the signed authorization.

_________ My evaluation, testing, diagnosis, or treatment concerning my mental health, rehabilitation, and/or neuropsychological information may be released to the recipient on the signed authorization.

_________ My evaluation, testing, diagnosis, or treatment for HIV/AIDS may be release to the recipient noted on this signed authorization.

AUTHORIZATION SIGNATURE

Note: If patient is under sixteen (16) years of age and is not an emancipated minor, the parent or guardian must sign. I understand that there will be a fee to cover the cost of copying and handling my records.

Signature: ____ Date: _________________________

Witness Signature: ____ Date: _________________________