O'Fallon Dermatology SPECIALISTS

# MEDICAL RECORD RELEASE REQUEST

I, _____authorize
Dr. Angela Spray and O'Fallon Dermatology Specialists

Patient Date of Birth:

Patient Chart Number:

_____ To Release and Provide To:

_____ To Request and Obtain From:

_____

_____

_____

The following Protected Health Information in Hardcopy Format (paper or fax) for the specific purpose of managing my overall medical/dermatology care:

_____ Complete Medical Records

_____ Biopsy / Pathology Reports

_____ Laboratory Results

_____ Other (please list) _____

I agree that this is a one time only request for the transmission of this specific Protected Health Information only and that once this information is successfully provided or obtained, this authorization is automatically revoked and no longer valid. I am aware that all information exchange methods pose certain risks to the privacy and security of Protected Health Information that may be beyond the control of O'Fallon Dermatology Specialists. I agree to assume such risks personally and to hold Dr. Angela Spray and O'Fallon Dermatology Specialists harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing O'Fallon Dermatology Specialists to release/provide or request/obtain such information in hardcopy format. I understand that information released or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to inspect this requested Protected Health Information. I understand that I have the right to refuse to sign this Authorization and that Dr. Angela Spray and O'Fallon Dermatology Specialists will not condition my care and treatment on whether I provide Authorization for the requested disclosure.

_____ _____

Signature of Patient or Representative Date

**For Office Use Only:**

HIPAA PHI Release Log _____

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