600 Suncrest Towne Centre, Suite 115
Morgantown WV, 26505
Phone 304-598-3888
Fax 1-304-721-4078

CONSENT FOR RELEASE OF MEDICAL RECORDS USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____

Date of Birth: ________________________________ Phone #: ____

Address: ____

City: ____ State: ____________ Zip Code: ____________

I hereby authorize Dermatology Center for Skin Health, PLLC to use or disclose the specific health information described below only for the purpose and parties as described.

I AM REQUESTING DERMATOLOGY CENTER FOR SKIN HEALTH, PLLC RELEASE MY MEDICAL RECORDS TO:

(Please choose one)

_____ PHYSICIAN (DIRECTLY TO PHYSICIAN - NO FEE)
_____ INDIVIDUAL (FEES APPLY)
_____ 3RD PARTY (FEES APPLY)

FORMAT OF RECORD RELEASE:

Please Note: Dermatology Center for Skin Health, PLLC will forward **2 years of medical records** unless otherwise indicated. Records released to the patient or a third party by paper copy will be subject to medical record fees in accordance with the WV State Law. Records faxed directly to a physician's office will be sent free of charge. Records going to the patient or 3rd party will need to pay the medical record fee (plus tax) *prior* to the release of records.

Please send records via: ___ Standard Mail ___FAX ___ Pickup in Office

Name of Health Provider: ____

Practice Name/Individual/Organization: ____

Street Address: ____

City: ______________________________________ State: _______ Zip Code: _________

Phone: _______________________________ Fax: _______________________________

INFORMATION TO BE DISCLOSED:

Please note: ***Only*** results/orders from Dermatology Center for Skin Health, PLLC providers will be released.

Date Range: ______________________________________to ____________________________________.

- All Medical Records (may contain reference to Super-Confidential PHI as listed below)
- Pathology/Biopsy Reports
- Lab Reports
- Surgical Reports
- Other (Specify) _______________________

SUPER-CONFIDENTIAL PROTECTED HEALTH INFORMATION:

Please note: The following information will only be released if checked with a signature. Otherwise, this information will be excluded from medical records release.

I authorize release of information of the following portions of my medical record:
___Mental Health ___ HIV/AIDS ___Substance Abuse ___Communicable Disease ___All
___ Only the following____________________________________

Signature: ____ Date: _________________

This Information is being requested for the following purpose(s):

___ Continued Care and Treatment ___ Changing providers ___ Moving to New Area ___ Insurance
___ Personal Use ___ Legal Reason ___ Workers Compensation ___ Disability ___ Request of Patient
___ Second Opinion ___Other ____

This authorization shall remain in effect from the date signed below until 1 year (expiration date or event).

I understand Dermatology Center for Skin Health, PLLC is complying with state and federal laws by warning recipient(s) records are prohibited from re-disclosure. **Initial____________**

I understand that the Dermatology Center for Skin Health, PLLC will receive compensation from a third party for the user or disclosure of my information. **Initial_____________**

I acknowledge that the Dermatology Center for Skin Health, PLLC, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed the NOPP of Dermatology Center for Skin Health, PLLC and have been given the opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated authorization shall be as effective as the original. I release, hold harmless, and agree to indemnify Dermatology Center for Skin Health, PLLC, its employees and agents for any and all liability (including but limited to negligence) arising out of or occurring under this Consent. I specifically authorize the Dermatology Center for Skin Health, PLLC to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the Super-confidential information (Psychotherapy, HIV, AIDS, Sexually Transmitted Diseases, BRAC, and Alcohol and Substance abuse records) as I indicated on page 1 of this form by checking the box and confirmed by my signature.

I may inspect a copy of my protected health information to be used or disclosed under this consent. I have the right to revoke this authorization in writing by contacting the Dermatology Center for Skin Health, attention Privacy Officer. Dermatology Center for Skin Health, PLLC has not conditioned provision of services to or treatment of my upon receipt of this signed authorization.

Patient Name (print): ________________________________ Patient Signature: ________________________________ Date: ________

Representative Name (print): _________________________ Representative Signature: _________________________ Date: ________

Relationship to Patient/Describe Authority: ____

WV State Law HB4560 Medical Records - “reasonable fees” can be charged for both paper and electronic copies of medical records. These cost-based fees include the costs of copying, supplies, labor for copying, and postage (if mailed).
In order for medical records to be processed, the fees which apply, must be paid in full PRIOR to the release of records. *Thank You.*