Russini Dermatology

A Division of Premier Dermatology

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REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RELEASE FROM:

Provider holding current patient's information:

Office Name

Provider First and Last Name

Mailing Address

City State Zip

Phone # Fax#

PATIENT INFORMATION:

I hereby authorize to use or disclose my PHI as indicated below to :

First Middle Last Name

DOB Gender

Mailing Address

City State Zip

Phone# Email

RELEASE TO:

I hereby authorize to use or disclose my PHI as indicated below to :

Russini Dermatology

3328 Bee Ridge Rd, Sarasota, Fl 34239
info@russiniderm.com
941.926.2300 TEL | 941.926.8424 FAX

ATTENTION:_____

INFORMATION TO BE RELEASED:

For dates of service from _____ to _____

- □ Complete Medical Record
- □ Biopsy Report(s)
- □ Lab Report(s)
- □ Consultation Report(s)
- □ Surgical Procedures
- □ Other _____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- □ Substance Abuse (Including alcohol/drug abuse)
- □ Mental Health
- □ Psychotherapy Notes
- □ HIV related information (including AIDS related testing)

This material shall not be transmitted to anyone without written consent or authorization as provided in these statues.

PURPOSE OF DISCLOSURE:

□ Changing physicians □Continuing Care □At my (patient) request □Second Opinion □Insurance □Legal
□ Other _____

RELEASE TYPE:

Check one: □Paper □Electronic □CD □USB fob
Check one: □Pick up □Mail □Fax Number _____ □Email Address _____

Comments:

This authorization will expire two years from the request date. | A photocopy of this form will be considered as valid as the original. | Patient may revoke this authorization at any time by notifying us at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. | Patient's health care and payment for his/her health care will not be affected if patient refuse to sign this form. | Patient will receive a copy of this form after he/she signs it. By filling out the information above the patient has given us permission to request his/her medical records.

By signing below, I acknowledge that I have read and understand this Request form.

Request Date _____ Patient Signature _____ OR Parent/Legal Guardian/Authorized Person Signature _____ Relationship to patient _____

Records Requested By _____ Date _____

For Office Use Only