

## Authorization to Disclose Health And/Or Billing Information

\_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Patient Name

Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

I, \_\_\_\_\_ give permission to \_\_\_\_\_  
Name of Patient Name of Facility

to release information to Charlotte Dermatology, PA

### Check information to Release:

- |   |   |
|---|---|
| <input type="checkbox"/> Complete Medical Records | <input type="checkbox"/> Biopsy Report (s)    |
| <input type="checkbox"/> Lab Report (s)           | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Medication Allergies     | <input type="checkbox"/> Surgical Procedures  |
| <input type="checkbox"/> Allergy Test / Treatment | <input type="checkbox"/> Other _____          |

For dates of service from \_\_\_\_\_ to \_\_\_\_\_

- 1- I can cancel this authorization at any time. I must cancel in writing and address it to the person or organization named above. I can't cancel consent for information already shared as a result of this permission.
- 2- I don't have to sign this form; refusal won't change my ability to get treatment, payment for treatment or benefits.
- 3- Once information is sent, it may not be protected by law and someone may be able to share my information with others without my permission.
- 4- I have read, understand and have been given a copy of this form.

Authorization expires 1 year after signature unless a date or event is written here: \_\_\_\_\_

\_\_\_\_\_  
Patient/Patient Representative Signature

\_\_\_\_\_  
Date

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Waverly Office 11840 Southmore Drive, Suite 170 Charlotte, NC 28277

University Office 8401 Medical Plaza Dr, Suite 260 | Charlotte, NC 28262    Myrtle Beach Office 8208 Devon Court, Suite B | Myrtle Beach, SC 29572

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