Charlotte Dermatology
A tradition of care since 1939

www.CharlotteDermatologyPA.com

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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:

_ Complete Medical Records
_ Lab Report (s)
_ Medication Allergies
_ Allergy Test / Treatment
_ Biopsy Report (s)
_ Consultation Reports
_ Surgical Procedures
_ 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