Arsenault DERMATOLOGY

Skin Care For Your Family

Authorization for the Release of Protected Health Information

Patient Name: ____________________ Patient Address: ________________________

Date of Birth: ____________________ ________________________

Social Security #: ________________ Patient Telephone: ________________________

I authorize Arsenault Dermatology to obtain/release a copy of the specific health and medical information described below:

(*check ONE option*): ☐ Arsenault Dermatology authorized to send my records to:

☐ Arsenault Dermatology authorized to obtain my records from:

____

Name of Physician, Facility, Patient or Authorized Representative

____

Complete Street Address **City** **State** **Zip Code**

____

Telephone Number **Fax Number**

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

1. *We cannot condition our provision of services or treatment to you on the receipt of this signed Authorization;*
2. *You may inspect a copy of the protected health information to be used or disclosed;*
3. *You may refuse to sign this Authorization; and*
4. *We must provide you with a copy of this signed Authorization.*

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.
Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

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Information to be Released:

_____	Complete Medical Records	_______	Biopsy Reports
_____	Initial Evaluation	_______	Lab Reports
_____	Follow-up Notes	_______	Surgical Reports
_____	Medications / Allergies	_______	Other:

Purpose of Disclosure: _____ Continued Medical Care ____ Personal Use

By signing below I authorize Arsenault Dermatology to release or obtain copies of my medical records. I understand that my record may contain information about alcohol and/or drug treatment, mental health or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above.

I understand that Arsenault Dermatology may utilize a medical record correspondence service and there may be a fee assessed for this service. PLEASE ALLOW 7 TO 10 BUSINESS DAYS FOR RECORDS TO BE COPIED.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under Federal law.

______________________________	______________________	__________
Signature of Patient/Legal Representative	***Relationship to Patient***	***Date***

64B8-10.003 Costs of Reproducing Medical Records:

1. Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records.

2. Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following:
   a. For the first 25 pages, the cost shall be $1.00 per page
   b. For each page in excess of 25 pages, the cost shall be 25 cents

3. Reasonable costs of reproducing x-rays, and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record as well as the labor cost and overhead costs associated with such duplication.

Specific Authority 456.057(18), 458.309 FS. Law Implemented 456.057(18) FS. History–New 11-17-87, Amended 5-12-88, Formerly 21M-26.003, 61F6-26.003, 59R-10.003, Amended 3-9-09.

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