VUJEVICH DERMATOLOGY ASSOCIATES, PC
DERMATOLOGY & COSMETIC SURGERY CENTER, PC

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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

PATIENT INFORMATION:

Name: _____ Previous Name: _____ Date of Birth: ___ / ___ / ___

AUTHORIZES:

I authorize Vujevich Dermatology Associates to ☐ Release Records to ☐ Obtain records from

Name of Health Care Provider or Entity | Address | City | State | Zip

_____ _____ _____ _____ _____

Phone Number: _____ Fax Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. The reason for the release of this information is:

☐ Continuation of care ☐ Changing to new provider ☐ Cancer claim form Policy # _____

☐ Personal Use ☐ Disability or other Legal Matter ☐ Other (describe) _____

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ Office Notes ☐ Operative Reports ☐ Laboratory Results

☐ Pathology results ☐ Itemized bills or financial statements ☐ Other (describe) _____

Release of records from the time period of _____ to _____ *if left blank, only the past (2) years will be disclosed.*

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until (2) years from date of execution at which time this authorization expires.

Signature of Patient or Legal Authorized Representative

_____ Date: _____

Witness Signature

_____ Date: _____

Office Use only:

Date Received: _____ Date Completed: _____ Staff Initials: _____