Medical Records Release Form
CENTRAL OHIO SKIN & CANCER

300 Polaris Parkway #3300
Westerville, Ohio 43082
Phone (614) 898-7546 Fax (614) 794-4294

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Last Name_____ First Name_____ Middle Initial_____

Address_____ City_____State_____ Zip Code_____

Phone Number (____)_____ Date of Birth_____

I hereby authorize the following health care provider and its physicians, employees and agents to release or disclose to the person or group named below and its representatives all of my medical records indicated below pertaining to treatment, prognosis, and diagnosis.

I authorize Central Ohio Skin & Cancer, Inc.: (CHOOSE ONE)

To release my medical records to:
Doctor or Facility_____
Address_____
City_____State_____ Zip Code_____
Phone (_____)_____Fax (_____)_____

To obtain my medical records from:
Doctor or Facility_____
Address_____
City_____State_____Zip Code_____
Phone (___)_____Fax (___)_____

Please send the following information: (PLEASE SPECIFY)

_____Complete records _____Laboratory Reports _____Pathology Reports Other_____

The purpose of this release is for the following reason: (PLEASE SPECIFY)

_____Personal Record _____Transfer of Care _____Insurance Purposes _____Other

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by privacy rules. To the extent that this form authorizes the sale of your PHI, such a disclosure will result in remuneration to COSC. By signing this form, you authorize COSC to use and disclose PHI about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the privacy officer of Central Ohio Skin & Cancer. This authorization will expire one year from date signed below.

Signature_____ Date_____

Relationship to patient (if other than patient)_____

Witness_____ Date_____