New Age Dermatology
Elvira Chiritescu, MD
1091 Pemberton Hill Rd, Suite 201
Apex, NC 27502

MEDICAL RECORDS RELEASE FORM

NOTE: we have gotten multiple calls from other dermatology offices that they **only want **BIOPSY (Path) Reports.** The complete medical record contains every medical entry in the chart and may be considerably more information than you or your provider need. Please select the most appropriate item below.

Patient Name: _____ DOB: _____

I hereby authorize to disclose my health information as follows:

FROM:	New Age Dermatology	TO: _____
	1091 Pemberton Hill Rd, Suite 201	_____
	Apex, NC 27502	_____
Phone#:	919-367-3625	Phone #: _____
Fax#:	919-367-3608	Fax #: _____

REQUESTED RECORDS:
☐ From (date): _____To (date): _____
☐ **Relevant Medical Record: Biopsy (Path) Reports**
☐ Surgical Procedures
☐ Other: _____
☐ Complete Medical Records (see note before selecting)**

PURPOSE OF DISCLOSURE:
☐ Change of Doctor
☐ Change of Insurance
☐ Referral to Specialist
☐ Other: _____

1) I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. 2) I understand that I have the right to revoke this authorization by sending a written notification and that a revocation is not effective if the information has already been disclosed but will be effective going forward. 3) I understand I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to New Age Dermatology. This request will expire one year from date of request.

Signature of Patient or Authorized Rep.: _____ Date: _____
Print Name of Authorized Representative: _____
Authority of representative to sign on behalf of the patient:
☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____