Skin Cancer SPECIALISTS, P.C. & Aesthetic Center
Dermatology • MOHS Surgery • Dermatopathology

Marietta
835 Cogburn Ave. NW
Suite 100
Marietta, GA 30060
770-422-5557

Newnan
2045 Hwy. 34 E
Newnan, GA 30265
770-502-0202

Cartersville
10 Cloverleaf Dr.
Cartersville, GA 30120
770-606-8026

Columbus
1150 Brookstone
Centre Pkwy.
Columbus, GA 31904
706-257-4189

Hiram
850 Charles
Hardy Pkwy.
Dallas, GA 30157
770-336-8888

Patient Authorization to Disclose Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____ Chart # _____

Patient Phone#: _____ Date Submitted: _____

I hereby authorize Skin Cancer Specialists, P.C. to release the following information contained in my medical records for the period from: _____ to _____.

Please check one of the three options listed:

☐ All PHI including confidential information (entire medical record)
☐ Only Laboratory information (i.e., pathology reports, bloodwork, cultures)
☐ Records Pertaining to Specified Date(s) of Service Only: _____

Though not required, it will certainly help improve our communication if the following question was answered:

The purpose of my medical record request is:

☐ My Medical or Life Insurance Company
☐ Another Doctor (I am moving)
☐ My personal record
☐ Another Doctor (changing care)
☐ Another Doctor (where I also receive care, e.g. cardiologist)
☐ Other (please specify) _____

Mail to (Name, Address, Phone Number, & Fax Number if applicable):

_____

_____

_____

I understand that these records will be handled in the most expeditious fashion possible. It is my responsibility to call and verify that the records have been transferred as requested. It is also my responsibility to seek further care for any understanding, condition, or malignancies.

I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality. Unless I otherwise revoke this authorization in writing, it shall expire on the following date, event, or condition: _____. At that time, no express revocation shall be needed to terminate my authorization. I hereby release Skin Cancer Specialists, P.C. from any legal responsibility or liability for disclosures that may arise as a result of the use of the information contained in the PHI released.

X_____ _____

Patient Signature/Guardian Relationship to Patient (if applicable)

The employee receiving this revocation must fill out the following information and then place the signed original in the designated place in patient's chart under the Medical Records tab.

Employee receiving request _____ Date Received _____Date Completed_____