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:

_____
Name of Health Care Provider 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. 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 ☐ Radiology results ☐ 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:

SEND TO:

_____
Name of Health Care Provider Address City State Zip

_____ _____
Phone Number Fax Number

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:**_____