LAKE NORMAN DERMATOLOGY, P.A.

20808 N. Main Street, Suite 103, Cornelius, NC 28031
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of birth: _____

Address: _____

City, State, Zip Code: _____

SS #: _____ Patient's phone #: _____

Date of Request: _____ **Date Needed:** _____

I authorize Lake Norman Dermatology to: OBTAIN INFORMATION / RELEASE INFORMATION
(CIRCLE ONE)

Name of provider or facility: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

PURPOSE FOR THIS REQUEST: ❒ Health care ❒ Insurance Coverage ❒ Personal ❒ Other

TYPE OF RECORDS REQUESTED:

- ❒ Immunization history
- ❒ All medical history related to a specific condition: _____
- ❒ All medical history from the dates: _____
- ❒ Treatment summary (includes history/physical, laboratory tests, radiology reports, operative reports, pathology)
- ❒ Specific information
  - ❒ Procedure report ❒ History and Physical ❒ Physical Therapy ❒ Laboratory/Pathology test results
  - ❒ X-ray reports ❒ Other: _____

AUTHORIZATION VALID FOR:

- ❒ This request only
- ❒ One year from the date of this authorization ***OR*** for all records prior to the date _____
- ❒ This request and for medical records of any future treatment of the type described until _____

I understand that:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment **information requires additional authorization.**

Charge for this service is as follows, according to North Carolina Law:
.75 per page 1 to 25, .50 per page 26 to 100, .25 per page 101 and over
with a $10.00 minimum plus postage fees

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Witness Date

For Office Use Only:

Date sent: _____ by: _____
via: ❒ mail ❒ fax
❒ picked up by: _____