FIRST COAST MOHS
DERMATOLOGY ASSOCIATES OF FCM ♦ FIRST COAST MOHS OF PONTE VEDRA
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (P.H.I.)

PATIENT'S NAME: _____ **BIRTH DATE:** _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **DAYTIME PHONE#** _____

RELEASE RECORDS FROM:	**RELEASE RECORDS TO:**
NAME: _____	**NAME:** _____
ADDRESS: _____	**ADDRESS:** _____
_____	_____
_____	_____
PH# _____ **FAX#** _____	**PH#** _____ **FAX#** _____

MEDICAL RECORDS: ____ **ALL or SPECIFIC DATES:** _____ **OTHER (PLEASE SPECIFY):** _____

BILLING RECORDS: ____ **ALL or SPECIFIC DATES:** _____ _____

SLIDES SPECIFIC DATES: _____ _____

SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION:
ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent. I UNDERSTAND that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

AS PART OF THE MEDICAL RECORDS CHECKS ABOVE, THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS CHECKED:
___ HIV/AIDS ____MENTAL HEALTH ____SEXUALLY TRANSMITTED DISASES ____DRUG/ALCOHOL

TIME PERIOD FOR DISCLOSURE: **___One –time or ___ 12 months beginning** _____

PURPOSE OF DISCLOSURE: **___Continuing treatment ___Residence Relocation ___Second Opinion ___Patient Request ___Transfer Records**

FOR PURPOSES OTHER THAN TREATMENT, PAYMENT AND OPERATIONS:
PATIENT IS TO RECEIVE A COPY OF AUTHORIZATION

___ RESEARCH ___ DISABILITY INSURANCE ___FMLA ___ LIFE INSURANCE ___ CANCER POLICY

___MARKING PROMOTION: I have been informed Scott D. Warren, M.D. P.A. ___ IS_X_ is not receiving any direct or indirect compensation from a third party as a result of disclosing information for this purpose.

****I UNDERSTAND THAT THIS AUTHORIZATION FOR NON-TPO WILL EXPIRE SIXTY DAYS FROM THE DATE OF SIGNATURE****

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. I HEREBY RELEASE SCOTT D. WARREN, M.D. P.A, FROM ANY AND ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THIS INFORMATION TO THE PARTY NAMED ABOVE.

I hereby authorize the use of disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may be conditioned on my signing this authorization. I further understand that if the organization/or individual authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. There, I release Scott D. Warren, M.D. P.A, from all liability from this disclosure of my health information.

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. I understand that the charge for this service is $1.00 per page for the first 25 pages and $0.25 for each page in excess of 25 pages, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Print Name of Patient: _____ **Print Parent or Legal Guardian:** _____

Patient Signature: _____ **Legal Guardian Signature:** _____

Relationship to Patient: _____ **Date:** _____

Send by: ____ Fax _____ (patient must initial approval) ___ Mail ___ Patient will pick up Records needed by: _____