

# Bluegrass Dermatology and Skin Surgery Center, PSC

## Authorization for Release of Protected Health Information

DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ PATIENT'S DATE OF BIRTH: \_\_\_\_\_

Purpose of release:  Request of individual  Transfer of care  Other: \_\_\_\_\_

I, \_\_\_\_\_, **HEREBY AUTHORIZE:**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

### **TO RELEASE MY RECORDS TO BLUEGRASS DERMATOLOGY**

Method of Receiving:  Mail Record  I will pick up  FAX (\*Providers only)

If you prefer us to mail your medical records please list the address: \_\_\_\_\_  
\_\_\_\_\_

If you would prefer we fax your medical records please list the appropriate fax number: \_\_\_\_\_

- Records covering period of time: \_\_\_\_\_ to \_\_\_\_\_  All dates of treatment  
 Records regarding treatment for the following condition(s) or injury(ies) **ONLY:** \_\_\_\_\_  
 Other: \_\_\_\_\_  
 Any and all medical records in the possession of Bluegrass Dermatology including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)

1. I understand this is the minimum amount of information necessary for the purpose described above. No other information will be disclosed.
2. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Office Manager at the address noted at the bottom of this form. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

\_\_\_\_\_  
Signature of Patient / Parent or Guardian

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Contact Telephone Number

John Buker, MD; Donna Roth, MD; Dana Black, MD; Pat Buker, MD; Danelle Owens, PA-C

3475 Richmond Road, Suite 200 Lexington, Kentucky 40509

Phone: 859/296-4400 Fax: 859/296-4300 Toll Free: 888/394-DERM (3376)

Website: [www.mohs.com](http://www.mohs.com)

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Purpose of release:  Request of individual  Transfer of care  Other: \_\_\_\_\_

I, \_\_\_\_\_, **HEREBY AUTHORIZE BLUEGRASS DERMATOLOGY, TO RELEASE MY RECORDS TO:**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

Method of Receiving:  Mail Record  I will pick up  FAX (\*Providers only)

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