Angela Wyatt Dermatology, P.C.

RELEASE OF PROTECTED HEALTH INFORMATION REQUEST

Patient Name: ____

Patient Address: ____

Patient Phone Number: ______________________

Patient Date of Birth: ______/______/______ Patient Social Security Number: __________-______-__________

By signing this request, I authorize **Angela Wyatt Dermatology, P.C.** to release certain protected health information (PHI) about me to:

Name: ____

Address: ____

Fax: ____

This authorization permits **Angela Wyatt Dermatology, P.C.** to release the following individually identifiable health information:

☐ Office Notes Dates: _____________________________ ☐ Pathology Report Dates: ____________________________

☐ Operative Report Dates: _________________________ ☐ Lab Report Dates: ________________________________

☐ Progress Note Dates: ____________________________ ☐ Entire Record

☐ Billing Records: _________________________________ ☐ Exclusions (If any): _______________________________

This information will be used or disclosed for the following purpose:

☐ Continuing Care ☐ Personal Copy ☐ Other: ________________________

The purpose is provided so that **Angela Wyatt Dermatology, P.C.** can make an informed decision whether to allow release of the information. This authorization will expire upon provision of the PHI specified above. The patient or legal guardian is not required to sign the authorization to receive treatment from **Angela Wyatt Dermatology, P.C.** The individual has the right not to sign; however, if the individual does not sign, the information will not be released. If the information is released to a party other than a health care provider, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

The undersigned gives approval to have this information transmitted by mail, fax, or electronic means, and has the right to revoke this authorization in writing except to the extent that the parties have acted in reliance upon this authorization. Any revocation must be submitted in writing to:

Angela Wyatt Dermatology, P.C.
ATTN: Records Release
1501 South Yale Street
Suite 152
Flagstaff Arizona 86001

The undersigned agrees to pay $1.00 per page for the first 25 pages of written material and $.25 for each additional page in addition to the actual cost of reproduction of non-written material such as photographs. The undersigned may request a copy of this form for personal records.

Angela Wyatt Dermatology, P.C.

RELEASE OF PROTECTED HEALTH INFORMATION REQUEST

By signing below, I acknowledge the following:

- I have read and understand the Release of Protected Health Information Request
- I agree to the terms outlined in the Release of Protected Health Information Request

Patient or Legal Guardian Signature:____ Dated:_________________

Patient Printed Name:____

Legal Guardian Printed Name:____
(if applicable)

Please return the completed form to the address above. You may fax completed forms to:

Angela Wyatt Dermatology, P.C.
ATTN: Records Release
928-779-6924