Trillium Creek Dermatology
YOUR SKIN EXPERTS

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: Date of Birth:

Address: Phone:

I authorize the release of my records to:

Name:

Address: Phone #:
Fax #:

How would you like the records sent? (Please Circle) Fax Mail Pick up at the office

What would you like to be sent? (Please Circle)
Entire Medical Record Biopsy Reports Lab Reports

Other:

I hereby authorize HMT Dermatology Associates, Inc. to furnish a copy of the above-mentioned information and related data, also known as PHI, of the above-named patient. I am aware that there may be information in this medical record that relates to substance abuse, mental illness, or HIV/AIDS that is of a highly confidential level.

I am aware that I can revoke this release at any time prior to the records being released to the above-named entity and that this release is valid for a limited time of 90 days.

I am aware of the $5 charge for all mailed copies. I am aware of the $20 charge for all transfers to insurance companies and law offices (billed to the corresponding offices).

Date Needed By:

Signature of Patient/Legal Guardian:
X_____

Witness:
X_____ Date:

You may email this request to hr@tcohio.com or fax to 330-662-0258. Your request will be completed promptly upon the return of this authorization, but please allow up to 30 days. If you have any questions, please contact 330-725-0569. Thank you.