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UNIVERSAL DERMATOLOGY, PLLC

ROCHESTER SKIN LYMPHOMA MEDICAL GROUP, PLLC

6800 Pittsford Palmyra Road, Suite 150, Fairport, NY 14450
Phone: 585-364-1177/585-364-1188
Fax: 585-678-9654

Authorization for Release of Medical Information

Patient's Name:_____ **Date of Birth:**_____

Address:_____ **Phone: (___)** _____

City/State/Zip:_____ **SSN:**_____

Purpose for this request: ☐ Healthcare ☐ Insurance ☐ Other

This Authorization allows Universal Dermatology, PLLC/Rochester Skin Lymphoma Medical Group, PLLC to:

☐ Send copies of your record to (or discuss your information with) the provider/person/facility below

OR

☐ Receive copies of your record from (or discuss your information with) the provider/person/facility below.

Name of Provider/Person/Facility:_____

Address: _____

City/State/Zip:_____

Phone: _____ Fax:_____

Type of Records/Information Requested:

☐ Inpatient: Dates_____

☐ Outpatient: Dates_____

☐ Clinic/doctor visit ☐ Laboratory test results ☐ Pathology reports
☐ Xray/imaging reports ☐ Emergency Dept records ☐ Other_____

I understand that my right to healthcare treatment is not conditioned on this authorization. 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 redisclosed; ***except*** that records protected by Federal Confidentiality Rules 42CFR, Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations. Release of HIV-related information requires additional authorization. There may be a charge for the requested records. The medical records requested above may be faxed in cases of medical necessity.

Signature of Patient or Representative:_____ **Date:**_____

Relationship to Patient (*if Representative*):_____