## Authorization to Release Medical Information/Transfer Records

**To: _____ (Physician or Practice to release records)**
**_____ ( Street address of Practice to release records)**
**_____ ( City, State Zip code or Practice to release records)**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), federal law pertaining to Early Childhood Intervention (34 C.F.R. part 300), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (N.C.G.S. 122C).

_____ _____
**Patient Name** **Date of Birth**

**RELEASE/TRANSFER RECORDS TO:**

Bluewater Dermatology and Skin Cancer Center, P.A.
144 Poole Road, Suite 101
Leland, NC 28451

Specify Records to be released (check all those that apply):

◯ Pathology/Lab Reports

◯ Melanoma Pathology/Surgical Reports

◯ Other Records: _____

**Purpose of the disclosure:** Transfer of Care to Bluewater Dermatology and Skin Cancer Center, PA

I understand that this authorization will expire one year from the date it is signed. **Initials:** _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any affect on any actions taken before the revocation was received. **Initials:** _____

_____ _____
**Signature of Patient or Patient's Representative (Form MUST be completed before signing).** **Date**

_____ _____
**Printed Name of Patient's Representative** **Relationship to Patient**