AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

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.

I authorize Blue Ridge Dermatology, P.A., to disclose the following information from the medical records of:

Patient Name:_____ **Date of Birth:**_____
Address:_____
_____
Phone:_____

Blue Ridge Dermatology, P.A., initiated an Electronic Health Records (EHR) system in 2014, and paper records prior to 2014 are not available.

Records paper copying fees covering the period of health care below (check one):

_____If you are requesting a paper copy of your records from the past 2 years (2023 through 2025) to be sent to another provider, there will be **no charge**. Please indicate their name, address, and phone number here:

Provider's Name: _____
Provider's Address:_____
_____
Provider's Phone: _____

_____If you are requesting a paper copy of your records from 2023 through 2025 to be picked up at our office by you or your authorized representative, there will be **no charge**.

_____If you are requesting a paper copy of your records from 2014 through 2025 to be picked up at our office by you or your authorized representative, the following **record copying fees will be charged** per North Carolina G.S. 90-411:

75¢ per page for first 25 pages, then
50¢ per page for pages 26 through 100, then
25¢ per each page in excess of 100

This information is to be used/disclosed for the purpose of:
_____Continuity of care
_____Other (specify)_____

Authorized Representative: The following individual is authorized to receive the above requested medical files on my behalf:

Name_____ Relationship:_____
Address:_____
_____
Phone: _____

Signature of Patient or Authorized Representative_____
Print Name_____
Date Signed_____

Please complete, sign, and date this form and mail or fax it to:

Blue Ridge Dermatology, P.A.
540 Hospital Drive
Clyde, NC 28721
Fax: 828-452-0939

Because of the time needed to finalize and print copies of medical records, we cannot generate them on a walk-in basis. After we receive your authorized release, we will prepare the copies and call you to let you know when the records are ready for pick-up. Please confirm the phone number to call: _____. If you need your records in any other format than paper, please call the office to discuss.