**AUTHORIZATION FOR RELEASE OF HEALTH RECORDS PURSUANT TO HIPAA**

Patient Name: Date of Birth:

Address:

I, or my authorized representative, request that health information regarding my care and treatment may be released as set forth on this form in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I fully understand the following:

* This authorization has no expiration date, unless otherwise specified by myself or authorized representative.
* Outside requests other than the patient, will be charged a fee of $55.00.
* Patient medical record requests will be charged a fee of $10.00. Medical records exceeding 20 pages will be charged an additional $0.10 per page.
* I may revoke this authorization at any time and must send such revocation to the Privacy Compliance Officer of the institution or medical practice responsible for the information I am requesting to be released.
* I understand that signing this authorization may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law.
* This information will be used for continuing medical treatment by the recipient physician, and/or for the purposes which I may request, as listed below:

**Name and address of health provider or entity to release this information:**

 Braun Dermatology Associates 2112 F Street NW Ste. 701 Phone: 202-293-7618 Washington, D.C. 20037 Fax: 202-775-1772

**Name and address of person, health provider, entity, or category of person to whom information will be released**:

 Phone: Fax:

**Specific information to be released:**

 Medical records from (date) to

 **Entire medical record** (patient history, office notes, tests results, pathology reports, and photos)

 Entire medical record, including: billing and insurance records, referrals, and consults

 Other (please specify)

**REASON FOR RELEASE OF INFORMATION:**

 At request of individual Continuing medical diagnosis and treatment

 Other (please specify)

**If not patient, name of representative signing form:**

**Signature of patient or representative authorized by law:**

**Date:**

**AUTHORITY TO SIGN ON BEHALF OF PATIENT:**

**Physician Releasing Records:**

**Date:**