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**AUTHORIZATION FOR RELEASE OF INFORMATION FORM**  
**(There may be fees associated with this record release)**

PRINTED PATIENT'S NAME: \_\_\_\_\_

PATIENT'S DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

Check Item needed	INFORMATION TO BE DISCLOSED	Date(s) of service or treatment
	Entire Record	
	Assessment/ History and Physical	
	Lab Tests or Procedure	
	Other (Please List)	

I understand that the information in my medical record may include information relating to sexually transmitted disease. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above. The information is to be released to:

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Patient requests records to be faxed to another facility or physicians office. Patient is aware of confidentiality risks involved and releases Buckeye Dermatology of responsibility of the fax.

FAX NUMBER: \_\_\_\_\_ INITIALS: \_\_\_\_\_

Check Item	PURPOSE
	Insurance or Other Third Party Reimbursement
	Continuity of Medical Care
	At the Request of the Patient
	Other: (Please Specify)

**METHOD OF PAYMENT**

CASH \_\_\_\_\_ CHECK# \_\_\_\_\_ AMOUNT \_\_\_\_\_

VISA \_\_\_\_\_ MASTER CARD \_\_\_\_\_ DISCOVER \_\_\_\_\_

I understand that if the person or entity that receives the information is not a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_