

Charlotte Dermatology, P.A.

Charlotte Office

2630 East Seventh Street • Suite 200
Charlotte, North Carolina 28204
Phone 704-364-6110 • FAX 704-364-4245

Matthews Office

101 East Matthews Street • Suite 800
Matthews, North Carolina 28105
Phone 704-847-7969 • FAX 704-849-2257

Authorization to Disclose Health or Billing Information

Patient Name _____ Date of Birth _____

Phone Number: Home _____ Cell _____

I, _____ give permission to _____
Name of Patient/Legal Representative Name of Facility

to release information to _____
Name/Address/Facility

Check information to Release:

- | | |
|--|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Biopsy Report (s) |
| <input type="checkbox"/> Lab Report (s) | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Medication Allergies | <input type="checkbox"/> Medication Allergies |
| <input type="checkbox"/> Allergy Test/Treatment | <input type="checkbox"/> Surgical Procedures |

For dates of service from _____ to _____.

1. I can cancel this authorization at any time. I must cancel in writing and address it to the person or organization named above. I can't cancel consent for information already shared as a result of this permission.
2. I don't have to sign this form; refusal won't change my ability to get treatment, payment for treatment or benefits.
3. Once information is sent, it may not be protected by law and someone may be able to share my information with others without my permission.
4. I have read, understand and been given a copy of this form.

Authorization expires 1 year after signature unless a date or event is written here: _____.

Patient/Patient Representative Signature

Date