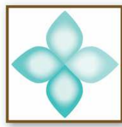

FERRARA DERMATOLOGY CLINIC
SKIN & LASER CENTER

Medical Records Release Fax: 313-884-9446

By signing this form, I authorize Ferrara Dermatology Clinic, P.C. to release copies of my medical records to the person and/or parties listed below:

Release all medical records from ____________to_____________ too the following individual and/or physician.
Name: ____
Address:____ City:__________________________
State:____________ Zip Code:_______________ Phone:________________________________

Specific information NOT to be released: (if applicable)

____

****There is a records' copying fee for each medical chart**** This fee may be paid over the phone or in person at no extra charge. Our office accepts Visa, Mastercard, Discover, American Express and personal checks.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA privacy rule. I have the right to revoke this authorization except to the extent that Ferrara Dermatology Clinic, P.C. has acted in reliance upon this authorization. My revocation MUST be in writing to the attention of the Privacy Officer.

Date: ___________________________

Patient Signature/Parent if Minor:____

Print Patient Name:____DOB:____________________

Office Staff Signature:_____________________________________ Date:_________________________