BLUE RIDGE DERMATOLOGY ASSOCIATES, PA

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# AUTHORIZATION FOR REQUEST OF MEDICAL INFORMATION RELEASED TO BRDA

_____ Print full Name

_____ Date of Birth

_____ Street Address

_____ Home Phone

_____ City, State, Zip

_____ Work Phone

**I do hereby authorize** _____
(Physician or Practice Name, Address and Phone Number)

**to release to BRDA the following:**

____ Discharge Summary
____ History & Physical
____ Progress Notes
____ Operative Notes
____Pathology Reports
____Lab Reports
____ ECG/EEG/Cardiac Cath
____ Other _____
____ Other _____

From the time period of _____ to _____

**Information Released To**: Blue Ridge Dermatology Associates, P.A.
3225 Blue Ridge Road Ste 101
Raleigh, NC 27612
Fax Number: 919-510-5090

**Purpose of Disclosure:**

_____ Referral to Specialist
_____ Legal Investigation
_____ Personal
_____ Insurance
_____ Disability Determination
_____ Change of Doctor

Please provide current daytime telephone number in the event we need to contact you: _____

*I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization.*

Signature of Individual or guardian or
Personal Representative of patient's estate: _____ Date: _____