AUTHORIZATION to RELEASE Medical Records TO Seacoast Dermatology, PLLC

SEACOAST DERMATOLOGY, PLLC
330 Borthwick Ave Suite 303 Portsmouth, NH 03801
17 Old Rollinsford Rd Unit 1 Dover, NH 03820
PH: (603) 431-5205 FAX: (603) 436-4257

Patient Name: _____ **DOB:**_____

Address: _____ **Phone:** _____

I authorize _____ to RELEASE my medical records to:

SEACOAST DERMATOLOGY, PLLC
330 Borthwick Ave Suite 303 Portsmouth, NH 03801
FAX: (603) 436-4257

Please provide all pathology reports and office visit notes from the last year unless requested otherwise.

Duration (If more than 1 year is requested): _____

I understand and acknowledge that my medical records may contain drug/alcohol, mental health, HIV, and or genetic testing information. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I may refuse to sign this authorization but my records will not be sent. I need not sign this form in order to assure treatment. I understand that I may see or copy the information to be disclosed. I may revoke this authorization in writing, at any time to the extent that the action has already been taken to comply with it. Written revocation is effective upon receipt. Re-disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will expire upon disclosure of requested information to the requested party.

_____

Signature of Patient (OR) Person Authorized to sign for patient Date

AUTHORIZATION for Seacoast Dermatology, PLLC to RELEASE Medical Records

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330 Borthwick Ave Suite 303 Portsmouth, NH 03801
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Patient Name: _____ **DOB:**_____

Address: _____ **Phone:** _____

Medical records are available for patients to view, download and print from the Patient Portal at www.SeacoastDermNH.com. Our office can help you log-in if you have not yet done so. You may also request that records be faxed or picked up from our office by providing the information below. Please allow up to 5 business days for the request to be processed.

_____**I authorize Seacoast Dermatology, PLLC to FAX my medical records to either myself or the healthcare provider/hospital below:**

Name: _____ **Fax #:**_____

_____**I choose to pick up my medical records from your office or to send an authorized agent to pick them up for me. (We will call you when they are ready.)**

Authorized Pick Up Name: _____**Phone:** _____

We will release pathology reports and office visits notes from the last year unless you request otherwise.

Duration (If more than 1 year is requested): _____

I understand and acknowledge that my medical records may contain drug/alcohol, mental health, HIV, and or genetic testing information. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I may refuse to sign this authorization but my records will not be sent. I need not sign this form in order to assure treatment. I understand that I may see or copy the information to be disclosed. I may revoke this authorization in writing, at any time to the extent that the action has already been taken to comply with it. Written revocation is effective upon receipt. Re-disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will expire upon disclosure of requested information to the requested party.

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