59 One Mile Road
East Windsor, NJ 08520
Phone: 609-443-4500 Fax: 609-426-0530

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

I,_____(**Name and Date of Birth of Patient making request**), hereby authorize
Windsor Dermatology, (hereafter collectively referred to as the "Practice") to use and disclose:

☐ My entire medical or record
☐ Test Results only
☐ Portions of my Medical Record, specifically: _____
☐ Date specific Portions of my Medical Record, From Date: _____ To Date: _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP (initial where appropriate):

☐ HIV records (including HIV test results) and sexually transmissible diseases
☐ Alcohol and substance abuse diagnosis and treatment records
☐ Psychotherapy records
***If not checked, no restrictions applied.

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____

2. Please have _____
release my records to: Windsor Dermatology (Name of Third Party).

3. The Records will be obtained by:

☐ Third Party will pick up a copy of my records on or after this date: _____
Or
☐ Direct mail (HISP) large or small file to: _____
Or
☐ Fax small file to: 609-426-0530
Or
☐ Send large file to this address: WINDSOR DERMATOLOGY, PC
EAST WINDSOR PROFESSIONAL WALK
59 ONE MILE ROAD EXT, STE G
EAST WINDSOR, NJ 08520

4. I acknowledge I may be charged a copying cost, made payable prior to the transfer of these records, in the amount of $ _____.

By Patient: _____ Date: _____
(**Sign name**)
Or
By Patient's Representative _____ _____ Date: _____
(**Sign name**) (**Relationship**)

OFFICE USE ONLY

Describe what alternative communications were denied this _____ day of _____, 20_____

_____

Describe what alternative communications were accepted this _____ day of _____, 20_____

_____