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

RECORD RELEASE TO PATIENT

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION {PHI}
TO INCLUDE SUPER CONFIDENTIAL PHI DIRECTLY TO THE PATIENT

I, _____, (**Name and Date of Birth of Patient making Request**), hereby request a copy of my health records·and authorize **WINDSOR DERMATOLOGY** , (hereafter collectively referred to as "this Healthcare Facillity") to use and disclose a copy *of* my health records to me.

I prefer my records be sent to me In the following format, but, understand that by law, the records can be sent in any electronic format similar if the format I desire is not available. I know this Healthcare Facility will supply me these records within 30 days of this request and, will contact me should there be any reason they need to extend this time frame. I understand, by law, this Healthcare Facility can request an extension for more time but, can only request an extension once for an additional 30 days.

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

The format which I prefer to receive my electronic records in is:
□ Fax a copy to (**fax number**): _____
□ Send a hard copy to (**address**): _____
□ Secured email a copy to (**email address**): _____
□ I will pick up a copy on or after (date): _____

I specifically authorize this Healthcare Facility 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.

The undersigned does hereby release, hold harmless and agree to indemnify this Healthcare Facility, it's employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization, I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law: that this authorization remains.effective until this Healthcare Facility is in actual receipt of a signed revocation or until !he records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so In writing; that I have been given an opportunity to ask questions; .that l have received, a copy of the signed authorization: that I may inspect a copy of my protected health information to be used or disclosed under this authorization: that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

By Patient:: _____ Date: _____
(**Sign name**)

Or

By Patient 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____

_____