Triangle Dermatology Associates

3008 Pickett Road
Durham, NC 27705
Phone: 919-286-7903 Fax: 919-286-7151

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

I request and authorize release of healthcare information of the patient named above to:

- Triangle Dermatology Associates

  Requesting from: _____

  Address: _____

  City: _____ State: _____ Zip Code: _____

  Phone:_____ Fax:_____

- Other: Name: _____

  Address: _____

  City: _____ State: _____ Zip Code: _____

  Phone:_____ Fax:_____

This request and authorization applies to (please list date(s) if applicable):

- All Healthcare Information
- Other (Please specify dates):

  _____

  _____

Reason for request:

- Moving
- Continuing Care by another Physician
- For my personal records

Records are to be sent via: MAIL FAX PATIENT PICK-UP

*List here the applicable address or fax number records are to be sent:

_____

****This authorization is effective immediately. This authorization is also subject to written revocation by the patient at any time which will be effective upon receipt. Please allow up to a week if requesting records to be sent. This authorization expires 90 days upon signing****

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Patient Signature: _____ Date: _____

TDA Employee processing this request:_____ Chart#_____ Date Processed:_____