PATIENT REQUEST FOR RELEASE OF AID RECORDS

ASSOCIATES IN DERMATOLOGY, INC.

You have the right to inspect and obtain a copy of your medical and billing records. This right does not apply to:

1) Psychotherapy notes.
2) Information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding.
3) Information that must or may be withheld from disclosure under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) or the Federal Privacy Act; and
4) Information obtained from a third party under a promise of confidentiality if the access requested is reasonably likely to reveal the source of the information.

Please identify specifically the information you are requesting:

___Complete Medical Records
___Records related only to the following date(s) of service_____
___Other (Specify) _____

Associates in Dermatology will act on this request within 30 days of the date listed above or, within 60 days if the requested information is stored off-site. If the requested information is contained in more than one designated record set or at more than one location, we are required only to provide you with access to information contained in one of the designated record sets.

Please indicate who you wish to receive a copy of the requested information and by what means (fax, mail, on-site) and provide the necessary fax number or address:

Send or fax to: _____

_____

Associates in Dermatology may impose reasonable fees to cover the cost of labor, copying, postage, and preparing a summary of the requested information.

Name (Print) _____ **Date of Birth**_____

Signature _____ **Today's Date**_____

Patient Representative_____ **Relationship**_____