NOVA
DERMATOLOGY

Authorization for Release of Medical Information

Patient:_____ Date:_____
Address: _____ DOB:_____
City/State/Zip:_____ Phone: __(____)_____

I authorize Nova Dermatology LLC to:
___ Send copies of your record to (or discuss information with) the provider/person/facility below
OR
___ Receive copies of your record from (or discuss your information with) the provider/person/facility below.

Name of Physician/Person/Facility: _____
Address: _____
City/State/Zip: _____

Phone: __(____)_____ Fax: __(____)_____

Information to be disclosed:
_____Progress Notes
_____Pathology/Lab Report(s)
_____Operative Notes
_____Cosmetic Notes
_____Entire Medical Record

Note: I acknowledge that there is a fee for obtaining paper copies of my medical records, $1.00 per page or $100.00 for the entire record, whichever is less. If the record requested is less than 10 pages, we may charge up to $10.00 to cover postage and the miscellaneous costs associated with retrieval of the record. There is no charge for electronic records faxed or pushed to the patient portal.

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature: _____Date: _____

Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to patient (if other than self): _____

Printed name of Authorized Representative: _____

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