OSEI - TUTU DERMATOLOGY

A: 560 Northern BLVD, Suite 204A, Great Neck NY 11021 |84 Linden BLVD, Brooklyn NY 11226
P: 516-506-0025 | F: 516-506-0032 | E: info@osei22derm.com | W: www.osei22derm.com

MEDICAL RECORDS RELEASE

Name:____

Date of Birth:____________________________SS#:______________________________

Address:____

City, State, ZIP: ____

Cell:_________________________Home:__________________________Email: ______________________

I hereby authorize Osei-Tutu Dermatology to release information from my medical record to (If self please indicate below):

Name:____

Address:____

City, State, ZIP: ____

Phone:_________________________Fax: _________________________

Reason for the release of information: ____

Describe information to be released: ____

Covering records from (Date)_________________to (Date) _________________

CONFIDENTIAL INFORMATION

I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.
I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.
I consent to disclosure of:

- ☐ My HIV-related information as detailed above
- ☐ My non-HIV medical information as detailed above
- ☐ Both (non-HIV medical and HIV-related information) as detailed above

This authorization will automatically expire within six months from the date of signature. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Osei-Tutu Dermatology. I understand that the revocation will not apply to information that has already been released in response to this authorization.
By signing this form I consent to the release of my medical information and/or HIV-related information to the person/people listed above.
I also understand that in order to process this request to reproduce medical record information, Osei-Tutu Dermatology, may charge a reasonable fee and/or utilize a photocopy service. My signature authorizes the release of information to such photocopy service for the purpose of satisfying this request and guarantees payment of reasonable fees. According to NY State law, a fee of $.75 per page plus postage may be charged.

Patient name (print)________________________Signature:________________________Date:________________