HILTON HEAD DERMATOLOGY & SKIN CANCER CENTER, P.A.

Certified, American Board of Dermatology • Certified, American Board of Mohs Micrographic Surgery and Cutaneous Oncology
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ACMS American College of Mohs Surgery

Cosmetic Laser Surgery
Diseases of the Skin, Hair, & Nails
Dermatologic Reconstructive Surgery
Mohs Micrographic Skin Cancer Surgery

CONSENT FOR RELEASE OF PATIENT INFORMATION

1. **Confidentiality**. Only patients can access records by signing below. For all others:
   - ☐ Insurance Company Signed Release
   - ☐ Family Member Power of Attorney
2. **Fees**. SC law 44-115-80 allows 0.65¢ per page 1st 30 pages, and 0.50¢ every other pages and a basic clerical fee of 10$ to search & duplicate medical records our policy is below. This request includes:
   - ☐ Entire chart ☐ Last visit
   - ☐ Other/dates_____ ☐ Last _____ Years
3. **Records provided without fees include**:
   - ☐ Pathology Report ☐ Second Opinion on a particular visit
   - ☐ Other_____ ☐ Insurance Processing of a claim
4. **Cost Calculation**: Basic Clerical Fee: $ 10.00
   Records Duplication: 0.65¢ x _____ 1-30 pgs = $_____
   0.50¢ x _____ 30+ pgs = $_____
   Invoice Total: $_____
5. **Authorization** **(All outstanding pathology needs to be accompanied by pertaining photos and maps)**
   I authorize Hilton Head Dermatology & Skin Cancer Center, PA:

   To receive medical records from: To send medical records to:
   Please provide complete Physician name, Telephone and Fax number.

   _____ _____
   _____ _____

6. **Purpose.** Though not required it will certainly help us improve our communication if the following question was answered. The purpose of my medical record request is because

   - ☐ I am moving out of town
   - ☐ I need a copy for my personal records
   - ☐ Other _____
   - ☐ I wish to change dermatologists
   - ☐ My insurance company requests a copy
   - ☐ I wish to see a plastic surgeon

7. **Appointment**. **I plan to keep my scheduled treatment date** ☐ Yes ☐ No MOHS_____ EXC _____

I understand that these records will be handled in the most expeditious fashion possible. It is my responsibility to call to follow up those records have been transferred as requested. It is also my responsibility to seek further care for any outstanding conditions or malignancies.

If you are not the patient, please specify the relationship to the patient: _____

Signed Printed Name DOB Date

Witness Printed Name Date

Please send medicals records to:	**COMMENTS:**
Hilton Head Dermatology & Skin Cancer Center, PA 15 Hospital Center Blvd Hilton Head Island, SC 29926 or fax to (843) 689-9201	