Secure Health Information Management (SHIM)
Custodian of Medical Records for
Dermatology & Skin Cancer Center, P.C.
Phone: (610) 930-5047

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name	Date of Birth	Telephone Number
Address	City, State, Zip	Social Security # (Last 4 digits)

Disclosed Information All Records

Covering the period(s) of care: 2010-2023 (Records forwarded from Advanced Dermatology in 2010 may be included if in DSCC chart.)

I would like these records: Copied to encrypted flash drive in PDF format

The records will be: Mailed upon payment of processing fee to SHIM. Call SHIM with credit card information.

I HEREBY AUTHORIZE SECURE HEALTH INFORMATION MANAGEMENT TO RELEASE TO:
(Encryption required for record security. All Dermatology practices in Lehigh Valley have password.)

Name of Person	
Address	
City/State/Zip Code	Telephone Number

Purpose/Use of the Requested Information

☐ Sharing with other health care providers (encrypted flash drive for security)

☐ Other (please describe)

Authorization

I hereby authorize Secure Health Information Management (custodian of medical records of Dermatology & Skin Cancer Center, P.C. ("DSCC") to disclose the health information described above.

NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. If not previously revoked, this authorization expires one (1) year from date of authorization.

Medical records shall be processed within thirty (30) days after we have received your request.

_____

Signature of Patient or Personal Representative Print Name Date

_____

Relationship of Personal Representative to Patient (If signed by other than patient) Date

Note to recipient of information: This information has been disclosed to you from the records protected by Pennsylvania Law. Pennsylvania Law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.