Bergen Dermatology Specialists
Medical • Surgical • Cosmetic

400 Route 17 South
Ridgewood, NJ 07450
Phone: 201-652-4536
Fax: 201-652-4906

180 Ramapo Valley Road
Oakland, NJ 07436
Phone: 201-337-5100
Fax: 201-337-7710

Please fax the form to the above listed number.

AUTHORIZATION TO USE AND/OR DISCLOSE PATIENT INFORMATION

Patient Information:	Name:______________________________ Date of Birth:______/______/______ Address:____________________________ Day Phone________________________
TO: (Who are the records going to? Fill out completely and legibly.)	Name:_________________________________ Attention to:___________________ Address:_________________________________ Day Phone:___________________ City:_____________________________________ State:_________ Zip:___________ Fax Number (for patient care only):____
From: (Where are the records coming from? **Fill out completely and legibly.**	Name:_________________________________ Attention to:___________________ Address:__________________________________ Day Phone:___________________ City:_____________________________________ State:_________ Zip:___________ Fax Number (for patient care only):____
Information to be Released: (What information and/or dates do you want released? Check appropriate box)	**Indicate Date(s) of Service for the records checked below:________________________or ❑ All Dates** **(*If left blank we will release 1 year's worth of most recent records*)** ❑ Entire Chart (or choose individual items below as needed) ❑ Visit Note(s) ❑ Pathology Report(s) ❑ Laboratory Report(s) ❑ Medical Care Photos ❑ Billing Statement(s) ❑ Other (please specify: i.e cosmetic photos, slides, etc.)____
Instructions for Release: (How and when is the information needed?)	**Date Information Due:_________________** **(please allow 7 business days for completion)** Release Method: ❑ Paper ❑ Fax (patient care only) ❑ Email ❑ Verbal
Purpose of Release: (Why is the information needed)	❑ Seeing Other Provider ❑ Insurance Payment/Claim ❑ Insurance Application * ❑ Personal Use * ❑ Litigation / Legal * ❑ Other * _________________________________ * Fees may be charged in accordance with NJ Statute NJAC 8: 43G- 15.3 and Federal Rule 45 C.F.R §164.524

- This authorization lasts for one year after the date of signature unless you enter a different date of expiration:__________________.
- This authorization may be canceled in writing at any time.
- Bergen Dermatology Specialists will not restrict treatment if you choose not to sign this authorization.
- Your records will be released once the fee is received. Call 201-652-4536 to pay by phone or send a check to the office.
- A copy of this authorization will be treated in the same way as the original.
- Bergen Dermatology Specialists cannot prevent redisclosure of your information by the entity who receives your records under this authorization and your information may no longer be protected by the Federal HIPAA Privacy Rule after release.
- Your signature indicates that you have read and understand this form and authorizes the release of your information as indicated above.

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Patient / Legal Guardian Signature Date Authority to act on behalf of patients (attach document)