FAIRLAWN DERMATOLOGY, LLC
VALERIE FULLER, D.O.
REQUEST TO TRANSFER RECORDS/INFORMATION

By signing this authorization, I authorize:

_____
Doctor's Office/Hospital to Send Information

_____
Address

_____
City, State, Zip Code

To send and/or disclose protected health information (PHI) about me to:

Valerie Fuller, D.O.
55 Merz Boulevard
Akron, OH 44333
330-864-9000
330-864-9004 Fax

This Authorization permits the party currently holding my records to send and/or disclose the following individually identifiable health information about me (specifically describe the information to be included, such as date(s) of service, type of services, level of detail to be released, origin of information, etc.):

This authorization will expire six months from the date of this form.

Please include:

_____ Pathology Reports
_____ Recent Blood Work
_____ Surgical Reports

Signed by: _____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____
Patient's name (if different from above) | Date

_____ _____
Print Name of Patient or Legal Guardian | Social Security Number or Birth Date

I do not have to sign this authorization in order to receive treatment from Fairlawn Dermatology, LLC. In fact, I have the right to refuse to sign this authorization. When my information is sent to disclose pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at 55 Merz Boulevard, Akron, OH 44333