

COASTAL DERMATOLOGY, LLC
MICHELE A. MITTELBRONN, M.D.

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY

Authorization for Release and Transfer of Medical Records and Protected Health Information

Patient's Name: _____ Account #: _____

Patient's Date of Birth: _____

Records Requested:

Method of Transfer Requested:

Pathology Reports: _____

Fax: _____

Lab Reports: _____

Mail: _____

Progress Notes: _____

Operative Notes: _____

I, _____, authorize Michele A. Mittelbronn, M.D. and Coastal Dermatology, LLC to obtain a copy of my medical records from:

I, _____, authorize Michele A. Mittelbronn, M.D. and Coastal Dermatology, LLC to SEND a copy of my medical records to:

Fee: \$25.00 for up to ten pages + \$0.50 per each additional page.

South Carolina statute [SC ST SEC 44-115-80](#) allows a medical practice to charge a fee for the search and duplication of a medical record and Coastal Dermatology DOES require payment of a fee for this service prior to sending requested medical records to anyone for any reason other than another physician for treatment purposes. Once we have received payment of \$ _____ we will forward the requested records within 30 days from receipt of your request and payment.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Representative

Relationship to Patient

Name of employee sending records: _____ [] Faxed [] Mailed [] Other: _____

Date Sent: _____

- Patient's may fax this authorization to Coastal Dermatology, LLC at:
Fax: 1-843-881-2789 or mail to: 999 Lake Hunter Circle, Ste B, Mt Pleasant, SC 29464 (Include \$25.00 fee)