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

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

A. Thomas Bundy, M.D., FAAD, FACMS

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 15$ to search & duplicate medical records our policy is below. This request includes:
   - ☐ Entire chart
   - ☐ Other/dates_______________
   - ☐ Last visit
   - ☐ Last __________ Years
3. **Records provided without fees include**:
   - ☐ Pathology Report
   - ☐ Other_____________________
   - ☐ Second Opinion on a particular visit
   - ☐ Insurance Processing of a claim
4. **Cost Calculation**: Basic Clerical Fee: $ 12.00
   Records Duplication: 0.50¢ x ________ pages = $ + _______
   Invoice Total: $_________
5. **Authorization**. I authorize Hilton Head Dermatology & Skin Cancer Center, PA:

   To receive medical records from:
   ____
   ____

   To send medical records to:
   ____
   ____

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.

I understand that these records will be handled in the most expeditious fashion possible. It is my responsibility to call to follow up that 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: Hilton Head Dermatology & Skin Cancer Center, P.A. 15 Hospital Center Blvd Hilton Head Island, SC 29926 or fax to (843) 689-9201	**COMMENTS:**