

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

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

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Cosmetic Laser Surgery  
Diseases of the Skin, Hair, & Nails  
Dermatologic Reconstructive Surgery  
Mohs Micrographic Skin Cancer Surgery

## CONSENT FOR RELEASE OF PATIENT INFORMATION

- Confidentiality.** Only patients can access records by signing below. For all others:
  - Insurance Company Signed Release
  - Family Member Power of Attorney
- Fees.** SC law 44-115-80 allows 0.65¢ per page 1<sup>st</sup> 30 pages, and 0.50¢ every other pages and a basic clerical fee of 10\$ to search & duplicate medical records our policy is below. This request includes:
  - Entire chart
  - Other/dates \_\_\_\_\_
  - Last visit
  - Last \_\_\_\_\_ Years

- Records provided without fees include:**
  - Pathology Report
  - Other \_\_\_\_\_
  - Second Opinion on a particular visit
  - Insurance Processing of a claim

- Cost Calculation:**

|                      |                          |    |              |
|----------------------|--------------------------|----|--------------|
| Basic Clerical Fee:  |                          | \$ | <u>10.00</u> |
| Records Duplication: | 0.65¢ x _____ 1-30 pgs = | \$ | _____        |
|                      | 0.50¢ x _____ 30+ pgs =  | \$ | _____        |
| Invoice Total:       |                          | \$ | _____        |

- Authorization** (All outstanding pathology needs to be accompanied by pertaining photos and maps)  
I authorize Hilton Head Dermatology & Skin Cancer Center, PA:

To receive medical records from:

To send medical records to:

Please provide complete Physician name, Telephone and Fax number.

\_\_\_\_\_  
\_\_\_\_\_

- 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 wish to change dermatologists
- I need a copy for my personal records
- My insurance company requests a copy
- Other \_\_\_\_\_
- I wish to see a plastic surgeon

- Appointment.** I plan to keep my scheduled treatment date  Yes  No MOHS \_\_\_\_\_  
EXC \_\_\_\_\_

I understand that these records will be handled in the most expeditious fashion possible. It is my responsibility to call to follow up those 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, PA  
15 Hospital Center Blvd  
Hilton Head Island, SC 29926  
or fax to (843) 689-9201

**COMMENTS:**