Cape Cod Dermatology, LLC

William W. Fiske, M. D.
Elizabeth M. Tocci, M.D.
Marie B. Schreiner, PA-C

134 Ansel Hallet Road
West Yarmouth, MA 02673
P: (508) 771-9779 F: (508) 771-4355

Please complete and sign below to release your records. The completed form may be
Mailed to: 134 Ansel Hallet Rd W. Yarmouth, MA 02673
Faxed to: (508) 771-4355
Emailed to: office@capecodderm.net

Records Release Form

Patient's Name: _____

Date of Birth: _____

I hereby authorize and request that you release copies of my medical records concerning my illness and/or treatment at Cape Cod Dermatology, LLC to the following party:

Name: _____

Address: _____

Telephone: _____ Fax: _____

If there may be any sensitive information such as information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, mental health treatment, HIV testing and/or AIDS diagnosis or treatment in your medical record that you do not want released, please indicate below.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards. I understand that all records will be transmitted via secure fax. Requests to mail records will be subject to a fee based on volume. A copy of this authorization is as valid as the original.

Patient: _____ **Date** _____