SKIN SURVEILLANCE PROGRAM
MELANOMA & SKIN CANCER EARLY DETECTION

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient

Last Name_____ First Name_____ MI_____
Address_____
City_____ State_____ Zip Code_____
Phone Number_____ Date of Birth_____
I hereby authorize_____to release my health information to:

MoleSafe USA
Attention: Jessica Story, Manager MoleSafe
30 Columbia Turnpike, Suite 201
Florham Park, NJ 07932
Phone#: (877) 665-3723; **Fax#:** (973) 218-9633

Information to be Disclosed

I understand that my name, date of birth, address, age, gender, phone number, other demographic insurance information will be included in any reason of health or billing information

_X_ All Pathology reports; ___ Specific dates_____; ___ *All Medical records

***Notice:** This authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of hospitalization and ambulatory visits. These records will be disclosed unless you specifically ask us not to disclose it in the "Exclusions" section below.

Exclusions: _____

Method of Disclosure (check one)

_X_ All Methods; ___In-person review; ___Paper copies faxed; ___Paper copies mailed
___Other_____

Why is this information being disclosed? (Check one)

___Continuing Treatment ___At the request of the Patient
___Other (Specify):_____

Important information for Patient/Patient Representative:

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do it in writing and present my written revocation to the manager of MoleSafe. I understand that this revocation will not apply to the extent that you have already taken action in reliance on this authorization. This authorization will **automatically expire in 90 days** from the date of my signature.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on the behalf of the patient.

***Signature of Patient/Patient Representative**_____**Date**_____
Legal Authority is: ___Guardian ___Parent of Minor ___Attorney in fact
___Next of Kin ___Executor of Estate ___Other
Patient is: ___Minor ___Incompetent/Incapacitated ___Disabled ___Deceased
Health Information Released by: Name_____Title_____Date_____