

**DERMATOLOGY
SPECIALISTS**

P. A.

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby request that my records be released from:

(doctor, clinic or hospital - requesting records)

(address)

Fax #: _____
(city, state, zip)

***** I hereby request that my records be released to:**

(doctor, clinic, hospital, or individual - requesting records)

(address)

Fax #: _____
(city, state, zip)

***** I hereby authorize and request the release of the complete records in your possession - Specifically:**

- _____ clinical summary / progress notes
- _____ operative notes
- _____ laboratory data
- _____ pathology reports
- _____ phototherapy notes

***** Concerning my illness and/or treatment during the period from _____ through _____.**

***** I am requesting that this information be released for the following purpose:**

_____ continued care _____ insurance claim _____ personal use
_____ attorney review _____ other _____

This will include any information related to HIV, drug and alcohol use, sexually transmitted disease or birth control, and mental health unless specified not to be released. With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated. I understand that this authorization must be filled out completely and signed in order to be considered valid. A copy or a fax that has NOT been altered will be considered as valid as an original.

PLEASE PRINT AND FILL OUT COMPLETELY:

***** Name:** _____ **Maiden Name:** _____

Date of Birth: _____

Address: _____

Signature: _____ **Date:** _____
(if relative of minor, state relationship)

This authorization will become part of your permanent medical record and will expire one year from the date signed. **Redisclosure Statement:** This authorization is specific for the stated physician, clinic or hospital only. I understand that in order to stop this release, I need to write to the Release of Information Department at Dermatology Specialists. I understand that once the health information has been released to another facility or provider, there is no way to cancel or stop what has already been released.

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Edina Minnesota 55435

TELE 952.920.3808

FAX 952.920.8899