

Authorization for Release of Information

Patient Information	Name: _____ Date of birth: _____ Address: _____ Day phone: _____ City: _____ State: _____ Zip: _____
I hereby request my records be released FROM: <i>(Who has the records you want released?)</i>	<input type="checkbox"/> Dermatology Specialists, P.A. <input type="checkbox"/> Other: Doctor/Clinic/Hospital – BELOW MUST BE FILLED OUT COMPLETELY Clinic/Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
I hereby request my records be released TO: <i>(Where do you want the records sent?)</i> Check the appropriate box(s)	<input type="checkbox"/> Dermatology Specialists, P.A. 3316 West 66 th Street, Suite 200, Edina, MN 55435 Phone: (952) 920-3808 Fax: (952) 920-8899 <input type="checkbox"/> Self (choose delivery method): <input type="checkbox"/> Mail OR <input type="checkbox"/> Email (encrypted) Email: _____ <i>(For unencrypted email initial here _____)</i> <input type="checkbox"/> Other: Individual/Doctor/Clinic/Hospital – BELOW MUST BE FILLED OUT COMPLETELY Clinic/Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
Treatment dates	If dates are left blank or incomplete, will release one year of the most recent records <input type="checkbox"/> All dates OR <input type="checkbox"/> Dates requested: ____/____/____ to ____/____/____ <small>MO DAY YEAR MO DAY YEAR</small> <input type="checkbox"/> Last 5 years
Records to be released Check the appropriate box(s)	<input type="checkbox"/> All records <input type="checkbox"/> Office visit notes <input type="checkbox"/> Laboratory (blood work) & imaging reports <input type="checkbox"/> Pathology reports <input type="checkbox"/> Other <i>(please specify)</i> : _____ <p style="text-align: center;">PLEASE ALLOW ONE WEEK FOR PROCESSING</p>
Purpose of release <i>(Why is it needed?)</i>	<input type="checkbox"/> Continued care <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Attorney Review <input type="checkbox"/> Personal Use <input type="checkbox"/> Transfer of care <input type="checkbox"/> Other: _____ <small>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.</small>

This consent will not expire until I revoke it in writing, unless I indicate a specific expiration date or event here: _____.

Re-disclosure 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.

Patient/Legal Guardian Signature (state relationship)

_____/_____/_____
MO DAY YEAR

For office use only:		
Account #'s _____	Physician _____ /	Staff initials _____

Dermatology Specialists, P.A.
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 Email: medicalrecords@dermspecpa.com