DERMATOLOGY SPECIALISTS

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**: *(Who has the records you want released?)*	☐ Dermatology Specialists, P.A. ☐ 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:** *(Where do you want the records sent?)* Check the appropriate box(s)	☐ Dermatology Specialists, P.A. 3316 West 66th Street, Suite 200, Edina, MN 55435 Phone: (952) 920-3808 Fax: (952) 920-8899 ☐ Self (choose delivery method): ☐ Mail OR ☐ Email (encrypted) Email: _____ *(For unencrypted email initial here_____)* ☐ 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 2 years of the most recent records** ☐ Dates requested: ____/____/____ to ____/____/____ *MO DAY YEAR MO DAY YEAR*
Records to be released Check the appropriate box(s)	☐ Medical record set (office visits, procedures, lab results, pathology results) **OR** check box(s) below ☐ Office & procedure visit notes ☐ Laboratory results & imaging reports ☐ Pathology reports ☐ Other *(please specify)* : _____ ***PLEASE ALLOW ONE WEEK FOR PROCESSING***
Purpose of release *(Why is it needed?)*	☐ Continued care ☐ Insurance Claim ☐ Attorney Review ☐ Personal Use ☐ Transfer of care ☐ 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.

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