CENTER FOR DERMATOLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information

_____ _____
Last Name First Name

_____ _____
Date of Birth Phone Number

_____
Street Address

_____ _____ _____
City STATE ZIP

Information released from:

_____
Clinic Name

_____
Clinic Address

_____ _____ _____
City STATE ZIP

FAX: _____

Information released to:

Center for Dermatology
20520 Keokuk Ave Suite 104
Lakeville MN 55044
952.469.5033 - phone
952.469.5069 - fax

Please disclose the following records: (Circle one)

Records pertaining to **Dermatology** OR Entire Patient Record

This information is to be released for the purpose of: (Circle one)

Patient Access **Continuing Care** **Other (specify)** _____

I authorize release of my medical records. This release will expire one year from date of signature.

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Send the written revocation to our office at the address listed above. *A photocopy/fax of this authorization will be treated in the same manner as an original.*
Further, I realize that Center for Dermatology cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to the privacy rule protections; therefore Center for Dermatology is released from any and all liability resulting from redisclosure.

_____ _____
Signature of patient/guardian Relationship to Patient

_____
Date of Patient's Signature

Scanned Printed Reviewed Sent