Patient Account Number: ____________________
Patient Name: ____________________
Date of Birth: ____________________
Phone Number: ____________________
Email (optional): ____________________

AUTHORIZATION AND REQUEST TO RELEASE MEDICAL RECORDS

PLEASE SPECIFY THE HEALTH RECORDS YOU ARE REQUESTING:

☐ Medical Office Records dated from ____________to ______________
☐ Cosmetic Office Records dated from ____________ to ______________
☐ Pathology Results dated from _______________ to _______________
☐ Lab Results dated from _____________ to _________________
☐ Other (please specify): ____ dated from ___________ to ____________

REASON FOR RECORDS REQUEST: ____
____

ASSOCIATED DERMATOLOGISTS MAY DISCLOSE THIS INFORMATION TO:

☐ Self (Patient requesting information) ☐ Physician's Office ☐ Other (Please specify):

Recipient Name: ____
Address: ____
City: ______________________________ State: ______ Zip: ____________
Telephone Number: ( ) ______________________ Fax Number: ( ) ______________________
Email: ______________________

DELIVERY PREFERENCE: ☐ Fax ☐ Pick Up ☐ Email: _____________ ______________ ☐ Mailed:

Address: ____

PLEASE NOTE: *For record requests exceeding 20 pages cannot be faxed; can only be emailed, picked up, or mailed.*

DELIVERY TIME: Records cannot be expedited for same day service. Records will be available within 7 days of request. If more time is needed, our staff will contact you with an estimated delivery time frame.

By signing this document as Associated Dermatologists patient, I, ____ understand that my right to healthcare is not conditioned on this authorization. I am also aware that it is my right to cancel this authorization at any time by submitting a written request to Associated Dermatologists, except where a disclosure has already been made in reliance on my prior authorization. I understand that if I am requesting my records to be sent to a person or facility that is not a health care of medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed. Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information will require a specific and additional authorization. As the patient I understand that this release authorizes the disclosure of records for one year from the date signed below.

Patient Signature: ______________________________ Date Signed: ______________________
If not patient, print name and your relationship to patient: ______________________________

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