Associated Dermatologists

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Request to Obtain Medical Records

Patient Information:

Name: ____
Date of Birth: ____
Phone Number: (____) __________________________________

Records Requested:

☐ Medical Records
- All Records
- For all records from dates ______________ to _____________

☐ Labs and/or Pathology Reports – Date/s: ______________________________

☐ Relating to a specific treatment, condition, or date:
____
____

☐ Other: ____

Records Requested From:

Name of Office/Physician: ____

Phone: (_____) ______________________ Fax: (_____) ____

Address: ____

City: ____ State: ___________ Zip: _______________

By signing this document, I, patient ____ 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 any time by submitting a written request to Associated Dermatologists, except where a disclosure has already been made in reliance on a prior authorization. I understand that if I am requesting my records to be obtained from a person or facility that is not a health care facility or a medical insurance provider covered by privacy regulations, the information obtained as 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 consent authorizes Contour Dermatology to request records for one year from the date signed below.

Associated Dermatologists is not responsible for how long it takes the requested parties to provide health records.

Patient Signature: ____ Date Signed: _______________