Attn: Medical Records Dept.
Dermatology Consultants, PA
60 Plato Boulevard E, Suite 270
St Paul, MN 55107
Phone: 651-209-1600
Fax: 651-291-9169

dermatology CONSULTANTS

AUTHORIZATION TO USE AND/OR DISCLOSE PATIENT INFORMATION

Patient Information	Name:______________________ Date of Birth:_____/_____/_____ Address:______________________ Day Phone:______________________
TO: (Who are the records going to? Fill out completely and legibly.)	Name:______________________ Attention to:______________________ Address:______________________ Day Phone:______________________ City:______________________ State:________ Zip:______________ Fax Number (for patient care only):______________________
FROM: (Where are the records coming from? Fill out completely and legibly.)	Name:______________________ Attention to:______________________ Address:______________________ Day Phone:______________________ City:______________________ State:________ Zip:______________ Fax Number (for patient care only):______________________
Information to be Released (What information and/or dates do you want released? Check appropriate box.)	Indicate Date(s) of Service for the records checked below: ______________ or ☐ All Dates (*if left blank we will release 1 year's worth of the most recent records*) ☐ Visit Note(s) ☐ Pathology Report(s) ☐ Laboratory Report(s) ☐ Entire Chart ☐ Billing Statement(s) ☐ Other (please specify)______________________ <u>Exclude</u> records pertaining to ☐ HIV / AIDS, ☐ Mental Health, ☐Genetic Testing, ☐ Drug / Alcohol Diagnosis, Treatment or Referral (<u>will</u> be included unless checked).
Instructions for Release (How and when is the information needed?)	Date Information Due:______________________ (please allow 7 days for completion) Release Method: ☐ Paper ☐ Fax (patient care only) ☐ CD / DVD ☐ Verbal ☐ View my Record
Purpose of Release (Why is the information needed?)	☐ Continuing Care ☐ Seeing Other Provider ☐ Insurance Payment/Claim ☐ Insurance Application * ☐ Personal Use * ☐ Litigation / Legal * ☐ Other * ______________________ * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R §164.524

- This authorization lasts for one year after the date of signature unless you enter a different date of expiration:______________.
- This authorization may be canceled in writing at any time.
- Dermatology Consultants will not restrict treatment if you choose not to sign this authorization.
- A copy of this authorization will be treated in the same way as the original.
- Dermatology Consultants cannot prevent redisclosure of your information by the entity who receives your records under this authorization and your information may no longer be protected by the Federal HIPAA Privacy Rule after release.
- Your signature indicates that you have read and understand this form and authorizes the release of your information as indicated above.

______________________ ______________ ______________________

Patient / Legal Guardian Signature | Date | Authority to act on behalf of patient (attach document)

Updated 7-22-13