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:_____/_____/_____<br>Address:_____ Day Phone:_____ |
| **TO:** (Who are the records going to? Fill out **completely and legibly**.) | Name:_____ Attention to:_____<br>Address:_____ Day Phone:_____<br>City:_____ State:_____ Zip:_____<br>Fax Number (for patient care only):_____ |
| **FROM:** (Where are the records coming from? Fill out **completely and legibly**.) | Name:_____ Attention to:_____<br>Address:_____ Day Phone:_____<br>City:_____ State:_____ Zip:_____<br>Fax Number (for patient care only):_____ |
| **Information to be Released**<br>(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<br>*(If left blank we will release 1 year's worth of the most recent records)*<br>☐ Entire Chart (or choose individual items below as needed)<br>☐ Visit Note(s) ☐ Pathology Report(s) ☐ Laboratory Report(s)<br>☐ Medical Care Photos<br>☐ Billing Statement(s)<br>☐ Other (please specify: i.e. cosmetic photos, slides, etc.)_____<br>• Check to Exclude records pertaining to ☐ HIV / AIDS, ☐ Mental Health, ☐Genetic Testing, ☐ Drug / Alcohol Diagnosis, Treatment or Referral (will be included unless checked). |
| **Instructions for Release**<br>(How and when is the information needed?) | Date Information Due:_____ (please allow 7 business days for completion)<br>Release Method:<br>☐ Paper ☐ Fax (patient care only) ☐ CD / DVD ☐ Verbal<br>☐ View my Record |
| **Purpose of Release**<br>(Why is the information needed?) | ☐ Continuing Care ☐ Seeing Other Provider ☐ Insurance Payment/Claim<br>☐ Insurance Application * ☐ Personal Use * ☐ Litigation / Legal *<br>☐ Other * _____<br>* 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)