ADVANCED DERMATOLOGY CARE

Medical, Cosmetic and Surgery, P.A.

~ Established in 1993 ~

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print with black ink.

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____ Social Security Number:_____

Information to be *Released From:*

Doctor.Clinic name:_____

Address: _____

City:_____State:____ Zip _____

Phone Number: _____

Fax Number: _____

Information to be *Released To:*

Name: _____

Address: _____

City:_____State:____ Zip _____

Phone Number: _____

Fax Number: _____

Information to be released (MUST CHECK ALL THAT APPLY):

☐ History & Physical ☐ Pathology Reports ☐ Progress Notes

☐ Billing information ☐ Lab Reports ☐ Other _____

All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by your signature here_____

Please indicate any restrictions (Specify): _____

For the following dates of treatment or condition: _____

I am requesting this information to be released for the following purposed: ☐ Verbal ☐ Continued Care

☐ Insurance ☐ Legal ☐ Personal Use ☐ Transferring Dermatology Care ☐ Other_____

May we ask why you are choosing to transfer your dermatology care?_____

Information will be mailed unless otherwise stated here: _____

- I understand I may revoke this authorization by written at any time to the address listed at the bottom of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lessor period of time as specified here:_____. The expiration period noted here may not exceed one year only in certain situations specified by law.
- I understand that once information is released pursuant to this authorization, ***Advanced Dermatology Care*** can not prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- A copy of this authorization is as valid as the original bearing my signature.
- Except for research-related treatment, ***Advanced Dermatology Care*** will not condition treatment on my signing this authorization.
- I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.

_____ _____ _____

Signature of Patient or Legal Guardian | Relationship to the Patient (Parent, guardian, health care power of attorney, etc.) | Date

_____

(Please give the reason that someone other than the patient is signing)

14130 60th Street North
Stillwater, MN 55082

4480 Centerville Road
White Bear Lake, MN 55127

25 North Lake Street, Suite 200
Forest Lake, MN 55025

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