

Authorization for Release of Medical Information



Patient Name: _____ Previous Name(s): _____
Address: _____ Date of Birth: _____
City: _____ State: _____ Phone: (_____) _____

I am requesting that health information be released **from:**

Clinic Name: _____
Address: _____ City: _____ State: _____
Phone: (_____) _____ Fax: (_____) _____

I am requesting that health information be released **to:**

Clinic Name: _____
Address: _____ City: _____ State: _____
Phone: (_____) _____ Fax: (_____) _____

Information to be disclosed:

- Entire patient record
- Pathology Reports
- Lab Results
- Records pertaining to date(s) of service: _____

Reason(s) for releasing information:

- Personal: _____
- Consult/Continuation of care: _____
- Change of health care provider: _____
- Changed insurance plan: _____
- Moved out of town: _____
- Legal/Disability: _____
- Other: _____

I hereby authorize Integra Dermatology PA or its' record custodian to release the information marked above. I understand I need not sign this form in order to assure treatment or payment. I understand that upon release, this health information is no longer protected by Integra Dermatology, PA and has the potential to be re-disclosed by the recipient. I understand there may be a charge for my records per Minnesota Statute 144.292.

Revocation: I understand that this authorization will be valid for 12 months from the date signed to release any records created to the date of the signature. Any records created after that date of authorization will require a new authorization. I understand that I may cancel this authorization, by sending a written cancellation to Integra Dermatology, PA or its' record custodian, and that the cancellation will take effect when Integra Dermatology, PA or its custodian receives my written notice.

Signature of Patient/Guardian: _____ **Date:** _____

*If not signed by patient, please send copies of legal documentation of representation.