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
- ☐ 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 up to the date of signature. Any records created after the date of this authorization will require a new authorization. I understand that I may cancel this authorization, by sending a written request for 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