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TRUSTED SKIN CARE

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AUTHORIZATION TO USE AND/OR DISCLOSE PATIENT INFORMATION

Patient Information	Name:_____ Date of Birth:____/____/____ Address:_____ Day Phone:_____
TO: (Who are records going to? Fill out completely and legibly)	Name:_____ Attention:_____ 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:_____ 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 only the last years' records.)* ☐ **All Medical Records** ☐Scans/Ultrasounds ☐Speech Therapy Notes ☐ Dictations ☐Occupational Therapy Notes ☐Most Recent History and Physical ☐ Psychotherapy Notes ☐Progress Notes ☐Lab Reports ☐ Operative Reports ☐Audilogy ☐Consultation ☐ Sleep Center Results ☐Xray Reports ☐Pathology Reports ☐ Other_____
Instructions for Release (How and when is the information needed?)	Date Information Due:_____ (please allow 7 days for completion) ☐Paper ☐Fax (patient care only)
Purpose of Release (Why is the information needed?)	☐ Continuing Care ☐Seeing Another Provider ☐Insurance Claim/Payment ☐ 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
- My Dermatologist 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.
- My Dermatologist cannot prevent re-disclosure 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 /Parent/ Legal Guardian Signature	Date	Authority to act on behalf of patient (attach document)