CENTRAL MINNESOTA
DERMATOLOGY

Authorization to Release Your Medical Record

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____ Phone#: (_____) _____

I authorize Central Minnesota Dermatology to release my medical record history to _____

Please select the information you would like to release:

- □ All records
- □ Histopathology reports
- □ Laboratory reports
- □ Visit notes
- □ Pictures
- □ Billing records

Other: _____

I understand that my records may contain restricted mental health, communicable disease (ex: HIV, AIDS, etc.), alcohol / drug abuse information. I do not wish to have this information disclosed: _____

This information is being requested for my Continuation of Care at my future appointment scheduled on _____.

Please send the selected records to:

_____

_____

_____

Signature of Patient / Legal Representative: _____

Date: _____ If not Patient: Parent: _____ Guardian: _____ POA: _____

This authorization will expire upon completion of this request. I understand that I have the right to revoke this authorization prior to its completion.

1903 South 6th Street, Suite 3 • Brainerd, MN 56401
Phone: 218-454-3376 • Fax: 218-454-4263
www.centralmnderm.com