CENTRAL MINNESOTA DERMATOLOGY

Authorization to Obtain Your Medical Records

Authorization is needed for us to obtain your medical records and have them sent to our office. Please specify which records you would like sent to our office so that we may most effectively participate in your care.

Patient information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Phone#: (_____) _____

Authorization:

I authorize the release of my medical information to Central Minnesota Dermatology from:

Provider/Clinic/Facility: _____

Fax Number: _____

Please select the information you would like to release:

- □ All dermatology related records
- □ Histopathology reports
- □ Laboratory reports
- □ Visit notes
- □ Imaging reports
- □ Pictures

Other: _____

Purpose of the disclosure:

- □ Continuity of care
- □ Legal
- □ Personal use
- □ Insurance
- □ Disability determination
- □ Other: _____

Please send the selected records to:

Central Minnesota Dermatology
1903 S 6th Street, Suite 3
Brainerd, MN 56401
Phone: 218-454-3376
Fax: 218-454-4263

Authorization Statements/Signatures:

1. I acknowledge that by signing this form, I have read and understand the above information and I authorize the release of the stated information.
2. I understand that the authorization lasts for one year from the date signed unless cancelled in writing.
3. I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to Central Minnesota Dermatology. I understand that the revocation will not apply to any information that has already been released in response to the authorization.
4. I understand that Central Minnesota Dermatology will not condition the provision of treatment or payment on the provision of this authorization.

Signature of Patient / Legal Representative: _____

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