



DERMATOLOGY
& CUTANEOUS SURGERY

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AUTHORIZATION FOR USE OF DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient Information:

Patient Name: _____ DOB: _____
Address _____ Phone: _____
City _____ State _____ Zip _____

Release Information To (check one):

- I hereby authorize Orah Dermatology and Cutaneous Surgery and its representatives to release my medical record information to the physician or facility listed below.
- I hereby authorize the physician or facility listed below to release my medical information to Orah Dermatology and Cutaneous Surgery and its representatives
- I hereby request and authorize Orah Dermatology and Cutaneous Surgery and its representatives to release my medical records to myself and/or family member listed below

Name/Facility: _____ Attention: _____
Address _____ Phone: _____
City _____ State _____ Zip _____ Fax: _____

Delivery Preference (check one):

- Mail copies to address listed above
- Hold for patient pick-up
- Fax: _____
- Phone: _____

Information To be Released (check one):

- Progress notes only
- Pathology reports only
- Other (specify records needed): _____
- Laboratory notes only
- All records

Purpose for Need or Disclosure (check one):

- Continued patient care
- Attorney/legal
- Other: _____
- Insurance claim/application
- Change of physical/relocation

I understand that the information release is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any employee of Orah Dermatology and Cutaneous Surgery and its representatives for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

Patient Signature Relationship to Patient (self, parent, spouse) Date

Please fax completed form or mail to address below, attention Medical Records.

For office use only. Staff Initial: _____ Date / time handled: _____ Means of transmittal: _____