Flatiron Dermatology

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Authorized Release of Medical Records

Please check and fill out areas as needed:

Date: ____________________

Patient Name**:** ____ Date of birth: _________________________

△Authorization to ***release*** my medical records to ***myself.***

△Fax ☐ Mail Pick up:

Fax: _______________________ Attn:_________________________________ Date of pick up:_______________

Phone: _____________________ Address:_______________________________

Attn: _______________________ _______________________________________

△Authorization to ***release*** my medical records to ***another facility***.

△Fax ☐ Mail Pick up:

Fax: _______________________ Attn:_________________________________ Date of pick up:_______________

Phone: _____________________ Address:_______________________________

Attn: _______________________ _______________________________________

△Authorization to ***request*** my medical records from ***another facility***.

To: ____

____

____

Tel: ______________________________ Fax: _____________________________

<u>INFORMATION TO BE RELEASED INCLUDES:</u>

☐ Chart notes
☐ Operative Reports
☐ Lab/Pathology Reports

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, or communicable disease, including HIV and AIDS.
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Signature: ____ Date: _____________________

Patient or Legally Authorized Representative