Aspen Dermatology
AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone (HOME):_____ **Phone (WORK):**_____

Address:_____ **City, State, Zip**_____

Above listed patient authorizes the following healthcare facility to make record disclosures:

Facility Name:_____ **Facility Phone:**_____

Facility Address:_____ **Facility Fax:**_____

City, State, Zip_____

The purpose of disclosure is:

- ☐ **Change of Physician**
- ☐ **Continuation of Care**
- ☐ **Referral**
- ☐ **Other**_____

Dates of information to disclose:_____

_____

Specific information requested:_____

_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied. This authorization is valid only for the release of medical information included within the dates specified by this authorization.

This information may be disclosed and used by the following individual or organization:

Release to:_____

Address:_____ **City, State, Zip**_____

Phone:_____ **Fax:**_____ **Email:**_____

☐ **Please email records** ☐ **Please mail records** ☐ **Please fax records**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____**. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ **Date:**_____

(Signature of Patient/ Parent/ Guardian or Authorized Representative-
Please attach documentation of Authorized Representative status)

_____ _____

Printed name of Authorized Representative **Relationship/Capacity to Patient**

_____**Staff initials**_____

Address and phone number or email of Authorized Representative