Authorization for Use or Disclosure of Protected Health Information to Skin P.C. Dermatology

Patient Name: ____ DOB: _________________________
Phone: ____________________ Address: ____
City: ____________________ State: _________ Zip: _______

Information May Be Released To: SKIN P.C. DERMATOLOGY

____
Skin P.C. Dermatology Provider

____
Address

____
City, State, Zip

________________ ________________
Phone Fax

Information Will Be Released From:

____
Practice/Doctor

____
Address

____
City, State, Zip

________________ ________________
Phone Fax

Please release the following information:

- ○ Progress Notes
- ○ Laboratory Reports
- ○ Other (specify records needed):
  ____
- ○ Pathology Reports
- ○ All Records

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 Skin P.C. Dermatology liable 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.

_____________________________ _________________________________ _____________
Signature of Patient/Legal Guardian Relationship to Patient (self, parent, spouse) Date

Authorization for Use or Disclosure of Protected Health Information

Patient Name: ____ DOB: ____________________________
Phone: ______________________ Address: ____
City: ______________________ State: __________ Zip: _______

Release Information To:
I hereby authorize Skin P.C. Dermatology to release my medical record information to:
Name/Facility: ____
Attn: __________________________________
Address: ____
City: ________________ State: _____ Zip: _______
Phone: ___________________________ Fax: ______________________________

Please release the following information:

- Progress Notes
- Laboratory Reports
- Other (specify records needed): ____
- Pathology Reports
- All Records

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 Skin P.C. Dermatology liable 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.

___________________________________ ________________________________ ___________
Signature of Patient/Legal Guardian Relationship to Patient (self, parent, spouse) Date

Please fax completed form to (402) 934-2719 or mail to 1408 Veterans Drive, Suite 100, Elkhorn, NE 68022 Attn: Medical Records. If you have any questions regarding this request, please call (402) 916-5665.