SKIN Spectrum
the art & science of dermatology

Medical Records Release

Patient Name: _____ DOB: _____

Skin Spectrum may disclose protected health information of the above-named patient to the individual or organization below:

Doctor / Office: _____
Address: _____
City, State, Zip: _____
Phone#: _____ Fax#: _____ Email: _____

Please forward a copy or summary of the following, from my medical record:

____ Complete Medical Record
____ Lab Report(s) - Which report(s): _____
____Photo(s) - Which photo(s): _____
____ Other: _____

Treatment Dates of protected health information to be disclosed: From_____to_____

This is: ____A one-time disclosure ____A continuing disclosure for 12 months

Purpose of Disclosure: ____Patient Access ____To Doctor ____To Insurance ____To Attorney

Method of Sending Records (Please circle one)

Mailed / Faxed / Picked-up / E-mailed*

*By selecting records to be sent via e-mail and by signing below, you are agreeing to your records being sent *unencrypted* and *not secure*.

I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality.
I hereby release Skin Spectrum from any legal responsibility or liability for disclosure that may arise as a result of the use of the protected health information.
I understand that authorizing the disclosure of this health information is voluntary; I may refuse to sign this authorization. I do not need to sign this form to ensure treatment.
I understand that if my records are being released to me, there is a medical records fee of $15.00 for the first 20 pages and $.25 for each additional page. If the records are placed on a CD, there is a $10.00 CD charge in lieu of a per-page fee.

Patient Signature: _____ **Date:** _____

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