North Pointe Dermatology

Patient Authorization to Release/ Request Medical Records

(Please print clearly- Records will not be processed unless this form is completed and signed by the patient / guardian)

Patient Information:

(Name of Patient) (Birthdate) (Phone #)

(Street Address) (City, State, Zip Code)

Authorizes:

(Name of Physician/Health care facility)

(Health care facility)

(Address)

(City, State, Zip Code)

(Phone#) (Fax#)

Release of Records to:

(Name of Physician)

(Health care facility))

(Address)

(City, State, Zip Code)

(Phone#) (Fax#)

Records requested:

Date(s) of service: _____/_____/_____ through _____/_____/_____

_____ Progress Notes _____Procedure Reports _____ Labs/ Pathology Reports

Reason for Request:

_____ Further Medical care _____ Personal _____Moving (specify) _____Others (specify)

_____

Signature:

By signing this form, I authorize you to release my confidential health information to the person(s) or entity listed above.
I understand this Authorization is valid for 1 year or the time specified unless revoked in writing.
Authorization valid for: _____

I understand that you will provide this information within 20 business days from the receipt of request and that a fee may be charged for preparing and releasing the requested information.

Patient/Guardian Name_____**Relationship**_____

Patient/Guardian Signature_____**Date**_____**/**_____**/**_____

For office use only: Date Information sent: _____ Processed By: _____

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