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PENINSULA
Dermatology
SKIN CANCER SURGERY CENTER

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MEDICAL RECORD RELEASE

Patient's Last Name _____ First _____ Middle Initial _____

Social Security # _____ Date of Birth _____

Home Address _____ City, State, Zip _____

I AUTHORIZE DERMATOLOGY SPECIALISTS TO:

❑ OBTAIN INFORMATION FROM ❑ RELEASE INFORMATION TO (INCLUDING DRUG AND/OR ALCOHOL RECORDS; HIV TESTING RESULTS, ETC.)

Name of Physician/Facility _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

PURPOSE OF THE USE OR DISCLOSURE:

❑ At the request of the individual (patient initiated authorization) ❑ Other (please specify) _____

REASON FOR REQUEST:

❑ Transferring to a new physician ❑ Records requested by specialist ❑ Other (please specify) _____

❑ Moving out of the area (new address) _____

INFORMATION TO BE PROVIDED:

❑ Entire medical record	❑ Laboratory reports	❑ Medications
❑ History & Physical	❑ Pathology reports	❑ Consultations
❑ Progress Notes	❑ X-ray reports	❑ Immunization record

❑ Other (please specify) _____

I understand that I have the right to refuse to sign this RELEASE. I understand that this RELEASE is valid for 12 months from the date of signature below, unless otherwise noted. EXPIRES _____ I understand that there will be a fee for copying medical records. I understand that I may revoke this RELEASE at any time by notifying DERMATOLOGY SPECIALISTS in writing. The revocation will only be effective from the date it is received by DERMATOLOGY SPECIALISTS and will not apply retroactively.

_____ _____
Signature of patient or parent/guardian if minor Date

_____ _____
Printed name of patient or parent/guardian if minor Relationship to Patient