

**Authorization for Release of Medical Information**

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip Code: \_\_\_\_\_  
SS#: \_\_\_\_\_ Patient's phone #: ( ) \_\_\_\_\_  
**Date of Request:** \_\_\_\_\_ **Date Needed:** \_\_\_\_\_

<b>OR</b>	
<input type="checkbox"/> I authorize Contour Dermatology and Cosmetic Surgery Center <b>to release information to:</b> _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)	<input type="checkbox"/> I authorize Contour Dermatology and Cosmetic Surgery Center <b>to obtain information from:</b> _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)

**PURPOSE FOR THIS REQUEST:** (Check one.)  Healthcare  Insurance coverage  Personal  Other  
 Transfer of Care

**TYPE OF RECORDS REQUESTED:** (Check one.)  
 Administered by Contour Dermatology only.  Include outside records submitted to Contour Dermatology.  
 All medical records related to a specific illness or injury.

Specify illness/injury \_\_\_\_\_ Date(s) of treatment \_\_\_\_\_

- Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
- Specific information (Select one or more, as applicable)
  - Procedure report  History & physical  Pathology results  Laboratory test results
  - Billing summary  Other \_\_\_\_\_  
(Please describe.)
- Entire copy of the record

**AUTHORIZATION VALID FOR:** (Check one.)  
 This request only.  
 One year from the date of this authorization **OR** \_\_\_\_\_. (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.  
 This request **and** for medical records of any **future** treatment of the type described above until: \_\_\_\_\_  
Insert Date

**I understand that:**

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

**NOTE: Medical records are faxed in cases of medical necessity only.**

Signature of Patient or Representative \_\_\_\_\_ Date \_\_\_\_\_  
Relationship to Patient (if requester is not the patient) \_\_\_\_\_