



MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below; I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY RECORDS TO: _____

PLEASE SELECT ONE DELIVERY METHOD:

☐ **REGULAR MAIL:** _____ **OR** ☐ **FAX:** _____
Mailing Address *Fax Number*

City, State, and Zip

Please forward a copy of the following medical records:

_____ COMPLETE MEDICAL RECORDS _____ CONSULTATION REPORTS _____ MEDICATIONS/ALLERGIES
_____ BIOPSY REPORTS _____ LAB REPORTS _____ SURGICAL PROCEDURES

For the following dates of service: _____ **to** _____

Today's Date: _____ Patient/ Guardian Signature: _____

PLEASE EMAIL YOUR REQUEST TO MRSCSM@dermcaremgt.com

IN ACCORDANCE TO STATUTE 64B8-10.003 COSTS OF REPRODUCING MEDICAL RECORDS:

I understand and agree that I am financially responsible for the following fees associated with my request of copying charges and production of my information. I understand that the charge for this service is as follows: For the first 25 pages, \$1.00 per page after 25 pages a charge of 0.25 cents per additional page.

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