DARABI
DERMATOLOGY

Medical Records Release Authorization Form

Patient Name: _____ Date of Birth: _____ Phone: _____

Patient Address:_____

I request that my medical records be released from:

Practice Name: _____ Provider Name (If Known): _____

Practice Address: _____

I request that my medical records be released to:

□ Darabi Dermatology □ Self □ Other Practice or Person (See Below)

Practice / Person Name: _____ Provider Name (If Applicable): _____

Practice / Person Address:_____

Phone #: _____ Fax #: _____

Information to be Released:

- □ Entire Medical Record Including All Visits, Pathology and Lab Reports, Photos, etc.
- □ Office and/or Surgical Visit Notes Only
- □ Pathology Reports Only
- □ Records pertaining to specific date(s) of service: _____

Reason for Disclosure:

- □ Other (Please Specify): _____
- □ Consultation / Continuation of Care
- □ Change of Provider
- □ Insurance Application
- □ Personal Records

In the event of health information being released from Darabi Dermatology; I understand that by signing this form I am requesting my health information be sent to a third party and that this information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that I may revoke this consent at any time by writing to the organization or professional who is releasing the records, else this consent will terminate one year from the date the form is signed, unless otherwise indicated.

Signature of Patient or Guardian: _____ Date: _____