Darst DERMATOLOGY

CONSENT FOR RELEASE OF MEDICAL RECORDS

☐ Request to transfer records **TO Darst Dermatology** from the office below

☐ Request to transfer records **FROM Darst Dermatology** to the office listed below

Office/Doctor Name: _____

Address: _____

Phone: _____ Fax: _____

_____	_____	_____
Patient Name (Printed)	**Patient Signature**	**Date of Birth**

PURPOSE FOR DISCLOSURE:

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Life Insurance

☐ Personal ☐ Legal ☐ Other: _____

_____ **Initial here:** I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication. I understand that this authorization shall be valid for one year; that I may revoke this consent at any time except to the extent that action has already been taken. The requestor may be provided with a copy of this authorization.

For office use only:

FOR DATES OF SERVICE FROM: _____ to _____

INFORMATION TO BE RELEASED:

☐ Pathology ☐ Lab Reports ☐ Surgical Notes

☐ Most Recent Progress Notes ☐ Clinical Photos ☐ All Information

_____	_____
Staff Signature	Date

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