REQUEST FOR RELEASE OF MEDICAL RECORDS

Records being sent from:
____ Affiliated Dermatologists S.C.
____ Other *If other, please provide your previous providers'*:
Name: _____
Clinic Location: _____
Phone: _____ Fax: _____

These records will be sent to Highlander Dermatology LLC.

This is to authorize the release of patient's:

__X__ complete medical record of chart notes/labs
____ records of care from_____ to_____ only
____ records of care concerning the following condition(s)_____
_____

__X__ pathology reports: All
____ other. Specify: _____

Patient's name: _____ DOB: _____

Records to be sent to: **[ ] Bradley Straka, MD [ ] Kristina Kleven, MD**
[ ] Courtney Papp, PA-C
Highlander Dermatology LLC
2607 N. Grandview Blvd., Ste. 125
Waukesha, WI 53188
FAX: 888-451-3921

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____

Signature of patient/patient's guardian Date

_____

Signature of witness date