O'Fallon Dermatology SPECIALISTS

MEDICAL RECORDS RELEASE

O'Fallon Dermatology Specialists will send medical records to:

Entity Name: _____

Address: _____

_____

_____

Fax: _____

Patient Name: _____

Patient DOB: _____

The following Protected Health Information shall be provided in hardcopy format (paper) or facsimile (preferred) for the specific purpose of managing my overall medical/dermatology care:

_____ Complete Medical Records

_____ Biopsy / Pathology Reports

_____ Laboratory Results

_____ Other (please list) _____

"I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I am not required to sign this authorization as a condition of treatment, payment, enrollment, or eligibility for benefits". I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

_____ _____

Signature of Patient or Representative Date

For Office Use Only:

Authorization to Release _____

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Phone 636.561.3277 • Fax 636.561.5280