

TRANSFER OF RECORDS FORM

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 Medical Director

Authorization for Use or Disclosure of Health Information

Please complete entire form to guarantee timely processing

Patient Name: _____ Date of Birth _____

Patient Address: _____

Home Phone Number _____ Cell phone _____

Person authorizing release of medical records Patient ___ Parent/Legal Guardian ___ Other ___

(Legal paperwork must accompany every release form if the requestor is not the patient or patient's guardian if the patient is under 18 years of age)

Records requested **FROM:**

Records to be **SENT TO:**

Name of organization _____	Name of organization _____
Name of provider _____	Name of provider _____
Address _____	Address _____
Address 2 _____ Phone _____	Address 2 _____
# _____ - _____	Phone # _____ - _____
Fax # _____ - _____	Fax # _____ - _____

Please send : All records including lab work/biopsies _____ Records only (no lab work or biopsies) _____

Lab work/biopsies only _____

Other: _____

Reason for Disclose or Use: Personal Use ___ Changing Provider ___ Insurance ___ 2nd Opinion ___ Attorney

___ Dissatisfied with Service ___ Primary Care Review ___

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices, practitioners, hospitals, and/or clinics that are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information related to pregnancy, sexually transmitted diseases, HIV testing, AIDS and any AIDS-related symptoms. It also includes any information concerning cancer, cancer testing and cancer results. I agree that a copy of this release shall be as valid as the original release. I understand the importance of following up with a dermatologist on a regular basis and I assume full responsibility for scheduling my own appointment with a dermatologist in the near future. I hereby state that I have read and fully understand the above statements as they apply to me. I hereby give consent to the use or disclosure of my medical records for the purpose stated above.

Patient/Guardian Signature _____ Date _____

Witness _____ Date _____