SkinMed Institute

MEDICAL
SURGICAL
COSMETIC DERMATOLOGY

Consent to Release of Medical Records

Patient name: ________________________________ **Date of birth:** __________________

Any former/alternative names patient has used: ____

I. <u>Patient's Authorization:</u> You may use or disclose the following health care information:

X All my health information maintained by the above named practice.

You may disclose this health information to:

Name:____

Address:____

Email: _________________________________ **Phone:** ____

Reason(s) for this authorization (check all that apply):
Transfer of medical records due to practice closing

This authorization ends: ____________*(One year from the date signed unless specified for an earlier time)*

II. Patient's Rights
I understand I do not have to sign this authorization to get health care benefits (treatment, payment or enrollment).However, I do have to sign an authorization form:

- To take part in a research study OR
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Please write a letter to the office if you wish to revoke this authorization. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. Patient waives any claims, demands, or causes of action arising out of or relating to SkinMed's transfer of medical records pursuant to this Consent to Release of Medical Records.

Patient Signature: **Date:** _________**Time:** _________

Signature of authorized individual & relationship to Patient: _________________________________
Date: _________**Time:** _________