REDWOOD EMPIRE DERMATOLOGY

6574 Oakmont Dr, Ste B, Santa Rosa 301 East St, Healdsburg
Tele: 707-579-4239 SR Fax: 707-579-0459 Hbg Fax: 707-433-4253

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

OR

I authorize Redwood Empire Dermatology to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City State Zip code

I authorize Redwood Empire Dermatology to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City State Zip code

Records and information pertaining to _____ _____
Name of Patient Date of Birth

_____ _____
Address including street, city, state, zip code Telephone Number including area code

PURPOSE FOR THIS REQUEST: ❒ Healthcare ❒ Insurance coverage ❒ Personal ❒ Transfer of care

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed.

❒ All medical records related to a specific illness or injury from: _____ to: _____
Dates of treatment

❒ Treatment summary (includes history, lab tests, operative reports, pathology)

❒ Copy of the entire medical record, as allowed by law.

AUTHORIZATION VALID FOR: (check one)

❒ This request only.

❒ One year from the date of this authorization **OR** _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a WRITTEN request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

A copy of this original is as valid as the original. Patient has a right to a copy of this authorization.

_____ _____ _____
Date Signature If signed by other than patient, indicate relationship