lakes dermatology

Medical Release Form
Authorization for Release of Information

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Information
Name _____
Address: _____
Date of Birth _____

Authorization
I authorize the release of my medical information from Lakes Dermatology.
Please select the information you would like to release:

☐ All records
☐ Visit notes
☐ Histopathology report
☐ Imaging reports
☐ Laboratory reports
☐ Other (specify) _____

Release information to:

_____
_____
_____
_____

Purpose(s) of This Disclosure:

☐ Continued Care
☐ Insurance
☐ Legal
☐ Disability Determination
☐ Personal
☐ Other _____

This authorization lasts for one year after the date of signature. It may be canceled in writing at any time. I understand that this authorization is voluntary and I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment, receive payment or affect my eligibility for benefits. My signature below indicates I have read and understand this form. I authorize the release of information as indicated above.

_____ _____
Signature of patient/Patient representative Date

_____
Print name