lakes dermatology

Medical Release Form
Authorization to Obtain Your Records

Authorization is needed for us to obtain your medical records and have them sent to our office. Please specify which records you would like sent to our office so that we may most effectively participate in you care.

Patient Information
Name _____
Address: _____
Date of Birth _____

Authorization
I authorize the release of my medical information from
_____
_____ to be sent to Lakes Dermatology.

Please select the information you would like to release:

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

Purpose(s) of This Disclosure:

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

Please send the selected records to:

Lakes Dermatology P.A.
☐ 14305 Southcross Drive, Suite 110, Burnsville MN 55306
Fax: 651-330-0429 Phone: 651-340-1064
☐ 14001 Ridgedale Drive, Suite300, Minnetonka, MN 55305
Fax: 952-303-3579 Phone: 763-316-4407

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