# MEDICAL RECORDS RELEASE AUTHORIZATION

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 Name: _____ Date of Birth: _____

**I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY RECORDS TO: _____**

**PLEASE SELECT ONE DELIVERY METHOD:**

**❒ REGULAR MAIL: _____** **OR** **❒FAX: _____**

*Mailing Address* *Fax Number*

_____

*City, State, and Zip*

**Please forward a copy of the following medical records:**

_____ COMPLETE MEDICAL RECORDS _____ CONSULTATION REPORTS _____ MEDICATIONS/ALLERGIES

_____ BIOPSY REPORTS _____ LAB REPORTS _____ SURGICAL PROCEDURES

**For the following dates of service: _____to _____**

Today's Date: _____ Patient/ Guardian Signature: _____

PLEASE EMAIL YOUR REQUEST TO MRSCSM@dermcaremgt.com

**IN ACCORDANCE TO STATUTE 64B8-10.003 COSTS OF REPRODUCING MEDICAL RECORDS:**
I understand and agree that I am financially responsible for the following fees associated with my request of copying charges and production of my information. I understand that the charge for this service is as follows: For the first 25 pages, $1.00 per page after 25 pages a charge of 0.25 cents per additional page.

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