Lake Dermatology
15 Executive Drive, Suite 4
Lafayette, Indiana 47905
Phone: 765-838-3428 Fax: 765-838-3440

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL RECORDS

PLEASE PRINT ALL INFORMATION EXCEPT FOR SIGNATURE AT BOTTOM

Patient Information

Name: _____ DOB: _____

Address: _____ City, State, ZIP_____

SSN (optional): _____ - _____ - _____ Phone: _____

I authorize Lake Dermatology to ☐ **Release to** ☐ **Obtain from**

Facility/Doctor: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Purpose for Release: Continuity of Care

INFORMATION TO BE RELEASED

☐ Visit Notes ☐ Pathology Related to Skin Disease ☐ Melanoma, Biopsy & Treatment

☐ Lab Results ☐ Entire Record ☐ Other (specify) _____

I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

The authorization will expire in 1 year unless otherwise specified: _____

You may revoke this authorization anytime in writing by notifying Lake Dermatology. The revocation will be effective upon receipt by Lake Dermatology unless Lake Dermatology has already taken action in reliance of this authorization. The provider may not withhold treatment if the patient refuses to sign this release.

Patient Signature: _____ Date: _____

Printed name of signee (& relationship if other than patient): _____