Lake Dermatology
15 Executive Drive #4
Lafayette, IN 47905
765-838-3428(P) 765-838-3440(F)

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL RECORDS

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 of release: Continuity of Care

***Note –** Complete medical record this may include communicable disease records, including sexually transmitted disease and HIV, substance/alcohol records, psychiatric records.

_____ Visit Notes _____ Pathology Related to Skin Disease _____ Lab Results

_____ Melanoma, Biopsy & Treatment _____ *Complete Medical 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 acted 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 (and relationship if other than patient): _____