DRIFTLESS
SKIN CENTER

Release of Information Authorization

Patient Name_____ Date of Birth_____ Phone_____

Address_____ City_____ State____ Zip_____

Authorization: The undersigned hereby authorizes Driftless Skin Center to:

( ) Release records to: ( ) Receive records from:

_____

_____

_____

Please fax all records to be received by Driftless Skin Center to 563-279-0653

Purpose of release

( ) Transfer ( ) Insurance ( ) Legal ( ) Continuity of Care ( ) Personal () Other_____

Please release the following health information:

( ) Complete medical record (previous 3 years) or,
( ) Medical records from dates _____ to _____ or,
( ) Lab reports/pathology reports or Other _____
Including, if applicable, the following protected health information will be released unless you restrict, please initial information you **DO NOT** want released:
___HIV/AIDS, ___Sexually transmitted disease, ___Mental health, or ___Substance abuse

I authorize electronic transmission (fax/ secure email) of my medical records. This authorization is valid for one year from the date on which it is signed. I understand that I may revoke this authorization in writing at any time to the Driftless Skin Center Privacy Officer, except to the extent that action has already been taken in reliance upon it. I understand that I have the right to inspect the information to be disclosed upon the proper notification.

Driftless Skin Center does not require completion of this as a condition of evaluation or treatment. However, if the evaluation or treatment is solely for the purpose of creating a medical report for a third party, those services are subject to cancellation if authorization to release to that third party is not provided.

I understand that the person or entity that receives the information requested may not be covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with a covered person or entity and the medical information may no longer be protected by the regulations.

I specifically authorize disclosure and redisclosure of this confidential information to the person or entity listed above. For this information to be released you must sign below.

Signature of Patient or Legal guardian_____ Date_____

Print Name and Relationship of patient's legal representative_____
(Authority to act on behalf of patient requires attachment of documentation)

Driftless Skin Center, P.C. 1550 University Ave, Ste B. Dubuque, IA 52001
Office- 563-900-8922 Fax- 563-279-0653

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