



Medical Release Form Authorization to Obtain Your Records

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

Patient Information

Name _____ Date of Birth _____

Address: _____

Best number to reach you during the day: _____

Authorization

I authorize the release of my medical information from _____
To be sent to Market Street Dermatology.

Please check below, which type of information you would like to be released.

- All records
- Visit notes
- Other (specify)
- Laboratory reports
- Histopathology report
- Billing records

Date range from _____ to _____

Please send the records listed above to:

Market Street Dermatology
275 Market Street, Suite 215
Minneapolis, MN 55405
Fax: 612-746-4149
Phone: 612-746-4144

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. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. 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

Witness

Date