Medical Release Form
Authorization to Transfer Your Records

Authorization is needed in order for us to obtain or send your medical records. The form below allows you to specify which records you would like sent so that we may most effectively participate in you 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:

☐ To be sent **to** Market Street Dermatology **from** _____

☐ To be sent **from** Market Street Dermatology **to** _____

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

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

☐ Other: _____

_____

_____

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