SkinSpeaks
Advancements in Dermatology | Spa M.D.
4725 36th Ave N. Crystal, MN 55422 · 763-231-8700 phone · 763-231-8711 fax

Authorization for Use or Disclosure of Protected Health Information

Name of Patient _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Request Records From:	Send Records To:
Clinic Name	Clinic Name or Patient Name
Street Address City, State, Zip	Street Address City, State, Zip
Phone # Fax #	Phone # Fax #

Information to be released:

From & To Dates _____

□ History and physical exam _____

□ Lab report _____

□ Biopsy report _____

□ Other _____

Purpose of Disclosure:

□ Changing physicians
□ Continuing care
□ At my (patient) request
□ Workers' Compensation
□ Other _____
□ School
□ Legal
□ Insurance
□ Second opinion

1. I understand that this authorization will expire one year from the day this form is signed. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying medical records at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS – related information, and psychiatric /mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I will get a copy of this form after I sign it, if requested.

By signing below, I acknowledge that I have read and understand this authorization.

_____ _____ **OR** _____ _____

Signature of Patient | Date | Parent/Legal Guardian/Authorized Person | Date

_____ _____ _____

Records Received By | Date | Relationship to Patient

For Office Use Only

Date Request Filled _____ By _____ Mailed/Faxed/Picked Up In Office