3919 W Jefferson Blvd, Suite B
Fort Wayne, IN 46804
Phone - (260)450-1313
Fax - (330)282-8009

Authorization for Release of Medical Records

Today's Date **:** _____ Date of Birth **:**_____
(mm/dd/yyyy) **(mm/dd/yyyy)**

Patient Name**:**

_____

1.) I authorize _____ to disclose my protected
(Name of practice/physician we are obtaining records from)

health information to **Integrative Dermatology & Laser Spa.**

2.) This authorization for release of information covers the period of healthcare from:
(Please mark the box that applies)

- ❑ **A:** From _____ to _____
- ❑ **B:** All past, future, and present periods

3.) This information will be use or disclosed for the following purpose:
(Please mark the box that applies)

- ❑ Continued Patient Care
- ❑ Insurance Claim/Application
- ❑ Attorney/Legal
- ❑ Change of Physician/Relocation
- ❑ Personal Use/ Personal Records
- ❑ Other: _____

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4.) Extent of Authorization -
(Please mark the box that applies)

- ❑ **A:** I authorize the release of my complete health record (including records relating to mental health care, communicable diseases (HIV or AIDS) and treatment of alcohol or drug abuse

- ❑ **B:** Other_____
  (Please specify what records you are requesting to be released - i.e.-Blood work, progress notes, specific date of service)

- ❑ **C:** I Authorize the release of my complete health record with the exception of the following information -

(Please mark all boxes that apply)

- ❑ Communicable diseases
- ❑ Alcohol or drug abuse care and treatment
- ❑ Mental health records
- ❑ Other **:**_____

5.) I understand that I am not required to sign this form and Integrative Dermatology Anti-Aging & Rejuvenation will not condition treatment, payment for services, or eligibility for services on whether I sign this form. I understand that my refusal to sign may result in improper diagnosis or treatment, denial of coverage for health benefits or other insurance or other adverse consequences.

6.) This authorization shall be in force and effect until_____ **,** at which time this authorization expires.
(30 days from now)

7.) I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.

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8.) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

9.) I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.

10.) I understand that I have a right to receive a copy of this authorization

By signing below I am acknowledging that I understand that all information obtained by the recipient will be held confidential in accordance with HIPAA privacy laws. I also understand that I may revoke this consent at any time.

_____	_____
Patient name	Patient signature
_____	_____
Relationship to patient **(i.e. - Spouse, self, parent)**	Today's Date

FOR STAFF ONLY -

_____	_____
Witness name and title	Today's Date