Integrated Dermatology of I Street
Medical Records Release Form

Print Name of Patient: ____

Date of Birth: ____________________

I. My Authorization

I authorize Integrated Dermatology of I Street to use or disclose the following health information.

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

____

☐ - My health information covering the period from ___________ (date) to __________ (date)

☐ - Other: ____

The above party may disclose this health information to the following recipient:

Name (or title) and organization ____

Address ____

City ____________________ State ____________________ Zip ____________________

Phone ___________________ Fax ____________________ Email ____________________

Signature of Patient: _________________________________ **Date:** __________________

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____________ years of age

☐ - Patient is unable to sign because: ____

Signature of Authorized Representative: _______________________________________

Date: _________________

Print Name of Authorized Representative: ____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: ______________________

******Please note there is a $25 fee for record request. Please allow 3 business days to complete request. Please include a copy of your photo ID when submitting request.***