Associated Skin Care Specialists

BOARD CERTIFIED DERMATOLOGISTS

Medical Dermatology
Mohs Surgery
Research
Cosmetic Services
Dermatopathology

Bart Endrizzi, MD, PhD
FAAD, ACMS
Frederick Fish, MD
FAAD, FACP, ACMS
Jeffrey Freed, MD
FAAD
Holly Hanson, MD, MHA
FAAD
Ngo Hien, MD
(in memoriam)
Susan Humphreys, MD
FAAD
Steven Kempers, MD
FAAD
Bailey Lee, MD
FAAD
Jane Lindholm, MD
FAAD, FASDP
Jane Lisko, MD
FAAD, ACMS
J. Daniel Mischke, MD
FAAD
Ann Norland, MD
FAAD
Soheil Pakzad, MD
FAAD
Scott Prawer, MD, MS
FAAD
Steven Prawer, MD
FAAD
Jeffrey Squires, MD
FAAD, ACMS
Roger Weenig, MD
FAAD, FASDP

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ **Date of Birth:**_____

Please release my records from: _____

Please release the records to: _____
(Name)

_____
(Address)

_____
(City,State,Zip)

_____
Fax Number (For patient care only)

Please release the following:

____Last Visit and Corresponding Pathology Report(s)

____Current Medical Record (we will release 1 year's worth of most recent records)

____Pathology Report(s) only ____Maps/Picture(s) ____Lab(s)

____Other (please specify dates):_____

All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released. Please initial here if you **DO NOT** authorize these records to be released: _____

For the following purpose(s):

____Personal Record ____Continuing Care ____Consult

____Insurance Claim ____Insurance Application ____Seeing other provider

____Other_____

This authorization will end one year from the date signed. I understand that I may revoke this authorization in writing at any time. A copy of this authorization will be treated in the same way as the original. Associated Skin Care Specialists cannot prevent redisclosure of your information by the entity who receives your records under this authorization and your information may no longer be protected by the Federal HIPAA Privacy Rule after release. By signing, I authorize the named above to use and/or disclose certain protected health information (PHI).

_____ _____
Signature of Patient or Legal Representative Date

_____
Authority to act on behalf of patient (attach document)