Authorization to release medical records

PATIENT INFO	
Patient name	______________________
Date of birth	______________________
Phone number	______________________

PURPOSE OF RELEASE				
Transfer	☐	Insurance	☐	
Moving	☐	Legal	☐	
Referral	☐	Other	☐	__________

COMPLETE ONLY ONE OF THE BOXES BELOW:

RELEASE INFORMATION FROM OUTSIDE FACILITY TO DUCHARME DERMATOLOGY, PC

Sending facility information:

Name: ______________________________

Address: ______________________________

City: ______________________________

State: ______________________________

Phone: ______________________________

Fax: ______________________________

RELEASE INFORMATION FROM DUCHARME DERMATOLOGY, PC TO OUTSIDE FACILITY

Receiving facility information:

Name: ______________________________

Address: ______________________________

City: ______________________________

State: ______________________________

Phone: ______________________________

Fax: ______________________________

ATTENTION SENDING FACILITIES:

Please fax records to **(833) 288-7944** or send via encrypted email to **info@ducharmedermatology.com**

INFORMATION REQUESTED:

Name of provider: ____

Service dates: ____

Requested information: All records: ☐ Pathology reports: ☐ Other (please be specific): ☐ ______________________

I understand that information to be released may include material that is protected by Federal and/or State law concerning mental health, substance abuse treatment, AIDS/HIV-related information and genetics unless I specifically deny the release by indicating to the right:

Substance abuse ☐
Genetics ☐
Mental health ☐
AIDS/HIV-related ☐

I authorize electronic transmission (fax or secured email) of my medical records. I understand that I may revoke this authorization at any time, except if records have already been shared. I understand that the receiving entity may not be covered by HIPAA. I specifically authorized disclosure and redisclosure of this confidential information to Ducharme Dermatology, PC or to the entity or person shown above:

Signature ______________________________

Printed name ______________________________

Relationship to patient ______________________________

Date ______________________________

Ducharme Dermatology, PC
16349 Sheridan Ave, Suite 101 • Clive, IA 50325
Ph: (515) 987-0333 • Fax: (833) 288-7944