AUTHORIZATION FOR RELEASE OF MEDICALRECORDS TO/FROM RADIANT COMPLEXIONS/IOWA DERMATOLOGY

Patient Information

Patient Name ______________________________ Date of Birth ____________________

Phone ______________________ Email ______________________________

Street Address ____________________ City ________________ State ______ Zip __________

Purpose Of Release

❑ Transfer ❑ Insurance ❑ Referral ❑ Moving ❑ Legal ❑ Per Patient Request ❑ Other ______________

Please complete below

Releasing information TO:

(Releasing information from outside clinic or facility to Radiant Complexions/Iowa Dermatology)

Clinic/Facility Name ____________________

Address ____________________

City ____________________

State __________ Zip __________

Phone __________ Fax __________

Email ____________________

Releasing information FROM:

(Releasing information from outside clinic or facility to Radiant Complexions/Iowa Dermatology)

Clinic/Facility Name ____________________

Address ____________________

City ____________________

State __________ Zip __________

Phone __________ Fax __________

Email ____________________

Name Of Provider/Service Dates

______________________________ / ______________

______________________________ / ______________

Information To Be Released (Check All That Apply)

❑ Complete Medical Records ❑ Other ____________________

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 related information and genetics unless I specifically deny the release by initialing the category below:

How Would You Like To Receive Your Records

❑ Mail ❑ Email ❑ Fax

I authorize electronic transmission (fax/secure e-mail) of my medical records. Records may be provided in electronic form on a secure disk. Paper records are available upon request. This authorization is effective for one year from the date on which it is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it. I understand I have the right to inspect the information to be disclosed upon the proper notification.

Radiant Complexions Dermatology does not require completion of this form as a condition of evaluation or treatment. However, if the evaluation or treatment is solely for the purpose of creating a medical report for a third party, those services are subject to cancellation if authorization to release the information to that party is not provided.

I understand that the person or entity that receives the information requested may not be covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with a covered person or entity and the medical information may no longer be protected by the regulations.

I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidential information to the person or entity listed above. In order for the information to be released, you must sign below. If mental health information is being disclosed, I acknowledge receipt of a copy of this authorization.

Signature of Patient or Patient's Legal Representative ______________________ Date ____________

Print Name and Relationship of Patient's Legal Representative ______________________

(Authority to act on behalf of patient requires attachment of such documentation.)

Please fax to 515-223-9341 or mail to Radiant Complexions Dermatology, 6800 Lake Drive, Suite 285 West Des Moines, IA 50266