CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ Request Date:_____ Date of Birth:_____
Authorization: The undersigned hereby authorizes Dermatology Associates of Siouxland, PC, and its employees to use and/or disclose to:

_____
Name of Person or Institution

_____
Complete Mailing Address/Street/PO Box City State Zip Code

Check the information to be disclosed – Information will be limited to the prior two (2) years, unless otherwise requested.

____ All Records
____ Progress Notes/Office Visits
____ Test results – Please specify type and date: _____
____ Other – Please specify type and date: _____

Specific Authorization for Release of Information Protected by State or Federal Law

I authorize the release of the information listed below, which requires specific consent under Federal and State Law.
(Must initial any category that may be released)

Substance Abuse _____ Mental Health _____ HIV related information _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Dermatology Associates of Siouxland, PC. I understand that any release that was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Dermatology Associates of Siouxland, PC.

I understand that Dermatology Associates of Siouxland, PC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

This agreement will expire one (1) year from the date of signature, unless previously revoked or otherwise indicated.

_____ _____
Signature of patient or legal guardian Date

_____
Relationship if not patient

This information has been disclosed to you from records protected by the Federal confidentiality rules (42 CRF Part 2). The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug use by patient.