REQUEST FOR MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Authorization: The undersigned hereby authorizes:

_____

_____

_____

and its employees to use and/or disclose to Dermatology Associates of Siouxland, PC the following health information:

( ) Complete medical record or,

( ) Medical records from _____ to _____ or,
date date

( ) Specific medical records as listed: _____

including, if applicable, the following health information related to testing, diagnosis, and/or treatment for: **(please initial applicable line):** _____HIV (AIDS virus), _____sexually transmitted diseases, _____mental health, or _____drug and/or alcohol abuse.

Expiration: This authorization shall expire upon the earlier of _____ or one year from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law. You have the right to revoke this authorization at any time by providing us with written notice by certified mail, fax or hand delivery to the following address:

Dermatology Associates of Siouxland, PC
2930 Hamilton Blvd., Ste. 102
Sioux City, IA 51104

When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

_____ Date _____
Signature of patient or legal guardian

_____
Relationship if not patient