CONSENT FOR RELEASE OF PATIENT INFORMATION

I, _________________________________ DOB: _________ authorize Skin Cancer Specialists:

To **receive** medical records **from:** ____
____
____

To **send** medical records **to:** ____
____
____

Though not required, it will certainly help us to improve our communication if the following question was answered. The purpose of my medical record request is:

- I am moving out of town.
- I need a copy for my personal records.
- I am changing my care over to a different office.
- My insurance company requests a copy.

- Other: ____

I understand this will include information relating to my condition and present medication regime and may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _______________.

I understand that information used or disclosed based on this authorization could be subject to re-disclosure by the party authorized to receive the records, and if so, may not be subject to federal or state law protecting this confidentiality.

I understand these records will be handled in the most expeditious fashion possible. It is my responsibility to call and verify that the records have been transferred as requested. It is also my responsibility to seek further care for any outstanding condition or malignancies.

______________________________________ ______________________________________
Patient Signature Patient Name Printed

____
Parent or Guardian/Legal Representative

_____________ __________________
Date Chart Number