

Request to Obtain Medical Records

Patient Information:

Name: _____
Date of Birth: _____
Phone Number: (_____) _____

Records Requested:

- Medical Records
- All Records with Contour Dermatology
 - For all records from dates _____ to _____

Labs and/or Pathology Reports

Relating to a specific treatment, condition, or date:

Other: _____

Records Requested From:

Name of Office/Physician: _____

Phone: (_____) _____ Fax: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

By signing this document, I, patient _____ understand that my right to healthcare is not conditioned on this authorization. I am also aware that it is my right to cancel this authorization any time by submitting a written request to Contour Dermatology, except where a disclosure has already been made in reliance on a prior authorization. I understand that if I am requesting my records to be obtained from a person or facility that is not a health care facility or a medical insurance provider covered by privacy regulations, the information obtained as stated above could be re-disclosed. Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information will require a specific and additional authorization. As the patient, I understand that this consent authorizes Contour Dermatology to request records for one year from the date signed below.

Contour Dermatology is not responsible for how long it takes the requested parties to provide health records.

Patient Signature: _____ Date Signed: _____