CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

Patient Chart Number: _____
Patient Name: _____
Date of Birth: _____
Phone Number: ( )
Email (optional): _____

AUTHORIZATION AND REQUEST TO RELEASE MEDICAL RECORDS

PLEASE SPECIFY THE HEALTH RECORDS YOU ARE REQUESTING:

☐ Medical Office Records dated from _____ to _____
☐ Cosmetic Office Records dated from _____ to _____
☐ Pathology Results dated from _____ to _____
☐ Lab Results dated from _____ to _____
☐ Other (please specify): _____ dated from _____ to _____

REASON FOR RECORDS REQUEST: _____

_____

CONTOUR DERMATOLOGY MAY DISCLOSE THIS INFORMATION TO:

☐ Self (Patient requesting information) ☐ Physician's Office ☐ Other (Please specify):

Recipient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone Number: ( ) _____ Fax Number: ( ) _____
Email: _____

DELIVERY PREFERENCE: ☐ Fax ☐ Email ☐ Pick up (**circle office**): Rancho Mirage Palm Springs La Quinta

PLEASE NOTE: *For record requests exceeding 30 pages cannot be faxed and can only be emailed or picked up. Records exceeding 30 pages will have a fee of $0.50 per page.*

DELIVERY TIME: Records cannot be expedited for same day service. Records will be available within 15 days of request. If more time is needed, our staff will contact you with an estimated delivery time frame.

By signing this document as Contour Dermatology's patient, I, _____ 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 at any time by submitting a written request to Contour Dermatology, except where a disclosure has already been made in reliance on my prior authorization. I understand that if I am requesting my records to be sent to a person or facility that is not a health care of medical insurance provider covered by privacy regulations, the information 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 release authorizes the disclosure of records for one year from the date signed below.

Patient Signature: _____ Date Signed: _____
If not patient, print name and your relationship to patient: _____