



Medical Records Request

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Purpose/Need for Records:

Personal Workers Compensation
 Insurance School
 Legal Other: _____
 Treatment/Continuation of Care

Records to be Released:

All Pathology/Labs/Imaging/Visit Notes Labs
 Pathology Imaging
 Visit Notes Dates of Service From: _____ to _____
 Billing Statements Dates of Service From: _____ to _____

I hereby authorize Advanced Dermatology & Skin Surgery to:

Send to: _____

Request From: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

If requesting for self, please put personal mailing address

1. I may revoke this authorization at any time by providing written notice to Advanced Dermatology & Skin Surgery, except to the extent that action has already been taken based on this authorization.
2. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Privacy Regulations.
3. This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

This authorization will expire 90 days from date signed.

Signature of Patient or Legal Guardian

Date

FOR OFFICE USE ONLY:

DATE COMPLETED: _____ **BY:** _____

THIS DOCUMENT IS INTENDED ONLY FOR THE PERSON OR OFFICE IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED CONFIDENTIAL OR PROTECTED BY LAW. ALL OTHERS ARE HEREBY NOTIFIED THAT RECEIPT OF THIS DOCUMENT DOES NOT VALE ANY APPLICABLE PRIVILEGE OR EXEMPTION FROM DISCLOSURE AND THAT DISSEMINATION, DISTRIBUTIION, OR COPYING OF THIS DOCUMENT IS PROHIBITED. IF YOU HAVE RECEIVED THIS DOCUMENT IN ERROR PLEASE NOTIFY US IMMEDIATELY AT 509-456-7414 AND RETURN THE DOCUMENT TO ADVANCED DERMATOLOGY & SKIN SUGERY VIA THE UNITED STATES POSTAL SERVICE. THANK YOU.