DERMATOLOGY, P.C.

6000 University Ave, Suite 450 West Des Moines, IA 50266 FAX (515-241-2005)

CONSENT TO REQUEST PROTECTED HEALTH INFORMATION **** THIS FORM MUST BE COMPLETED IN FULL OR IT WILL DELAY YOUR REQUEST ****

Patient name:	Date of Birth.	
By signing this form, I authorize the following entity to		nined below:
, and the same same same same same same same sam	Toleado my marviada nedia miormation as determ	illied below.
Authorizes:		
Name of Clinic/ Business:		
Provider Name:		
Address:		•
City/State/Zip Code:Phone Number:	Fare Name Is an	
Filone Number.	rax Number:	
This authorization permits DERMATOLOGY P.C	to receive the following information (Pleas	e select from the following:
Release records from time period of	to (if left blank only the past 2	vears will be disclosed)
Office Visit SummariesLab Reports	Procedure Reports	yours will be disclosed,
SPECIFIC AUTHORIZATION FOR THE RELEASE O	F RECORDS PROTECTED BY STATE AND FED	ERAL LAW:
I specifically authorize the release of medical reco	ords relating to: (please check the appropriate	
	Health □ Yes HIV-related information	1
	□ No	
This information has been disclosed to you from reco CFR part 2, state law for mental health records, (lowa	code Ch 141) These rules/laws prohibit you from	further disclosure of this
information unless expressly permitted by the written of	consent of the person to whom it pertains or as of	nerwise allowed by law A
general authorization for release of medical or other in	nformation is insufficient for this purpose. Civil dar	nages and criminal penalties
may be applicable to the unauthorized disclosure of the	nis information. The federal rules pertaining to alco	ohol/drug abuse records restrict
any use of the information to criminally investigate or	prosecute any alcohol or drug abuse patient.	3
Signature of water to a large		
Signature of patient or legal guardian	Date	
Please specify the reason for the release of thes	e medical records:	
Transferring medical careInsurance_	Legal Personal	
Continued CareDissatisfied with CareOther (Describe)		
SEND RECORD TO:	DERMATOLOGY P.C.	
600	0 University Ave, Suite 450	
We	est Des Moines, IA 50266	
	FAX (515-241-2005)	
Town I and the state of the sta		
I understand that I have the right to inspect the di	isclosed information at any time. When my inf	formation is used or
disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient as shown above and may no		
longer be protected by the federal HIPAA privacy	Rule. I have the right to revoke this authorize	ation except to the extent
that DERIVIATOLOGY, P.C. has acted in reliance	upon this authorization for record release pri	or to my written revocation.
This authorization will expire 60 calendar days from	om the signature date.	
	· ·	
Signature of patient or legal guardian	Relationship	Date
Address	City	
	City State Zi	p Code