DermOne™
Dermatology Centers

Authorization for Release of Medical Record Information
DermOne Dermatology Centers

Patient Information		
Last Name	First Name	MI
Street Address		
Date of Birth: / /	Email:	
Phone: ( )	Fax: ( )	
DermOne has my permission to release information contained in the medical record of the above named patient.		
Information requested (please be specific with dates if known):		
Restrictions/exclusions (if any):		
Purpose of release:		
DermOne will provide the information requested above to the following party (if applicable):		
Name	Attention	
Phone: ( )	Fax: ( )	
Street Address		

I hereby authorize DermOne to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded. I am aware that DermOne cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at DermOne may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire one (1) year from the signature date. Copy fees may be associated with this request for records. I can cancel this authorization in writing at any time, except to the extent that DermOne has relied upon it. For example, if I cancel it after DermOne has sent requested records, DermOne will not retrieve those records.

_____ _____
Signature of Patient / Authorized Representative Date

_____ _____
Printed Name Relationship to Patient*

* Patients over 18 years of age must sign their own release form. If this document is signed by a Power of Attorney (PoA) please include evidence of your PoA.