Tareen Dermatology
MEDICAL | SURGICAL | COSMETIC
• ROSEVILLE • FARIBAULT
• MONTICELLO • EAGAN
• MAPLEWOOD • HUDSON
651.633.6883
tareendermatology.com

Authorization for Release of Protected Health Information

Patient Name: _____ **DOB**: _____
Street Address: _____
City: _____**State:** _____ **Zip:** _____ **Phone:** _____

This Release Authorizes: Facility Name: _____
Address: _____
Phone: _____ Fax: (REQUIRED) _____

To Release To: Facility Name: _____
Address: _____
Phone: _____ Fax: (REQUIRED) _____

How would you like records sent: ☐ Faxed ☐ Mailed ☐ Office Pick-up ☐ Emailed _____

Please specify the type of information to be disclosed below: (There may be a fee to process this request)

☐ Complete Health Record	☐ All Available or Specific Date Listed _____
☐ Surgical/Hospital Reports	☐ All Available or Specific Date Listed _____
☐ Laboratory Reports	☐ All Available or Specific Date Listed _____
☐ Radiology (Reports/Films)	☐ All Available or Specific Date Listed _____
☐ Consultation Reports	☐ All Available or Specific Date Listed _____
☐ Progress Notes	☐ All Available or Specific Date Listed _____
☐ Billing Records	☐ All Available or Specific Date Listed _____
☐ Other: _____	☐ All Available or Specific Date Listed _____

This information is to be used for: ☐ Medical Care ☐ Personal ☐ Other: _____

Drug and/ or Alcohol Abuse, Communicable Disease, Psychiatric, HIV/AIDS, and/or Genetic Testing Release:
I agree that any information regarding Drug and/or Alcohol Abuse, Communicable Diseases, Psychiatric, and/or Genetic Testing may be released. ____ YES (Initial) ____ NO (Initial)

I agree that any medical or billing record containing information regarding HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment may be released _____ YES (initial) _____NO (initial)

I understand that I can revoke this authorization any time by submitting a written request to the medical records departments at the location where the records are stored. I also understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act (HIPAA) of 1996.
This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____.

Patient/ Authorized Representative Signature: _____ **Date:** _____

Relationship to Patient: _____ **Witness:** _____