AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO
TOWN SQUARE DERMATOLOGY
1100 6TH STREET, SUITE 202 |CORALVILLE, IA 52241|P: 319.337.4566 | F: 319.337.4766

I____ (Patient Name) _______________(Date of Birth)

Physician Name____
Address____
Phone____________________________ Fax:_____________________________________
This authorization for release of information covers all past, present, and future periods.

Check the information to be disclosed (include dates where indicated):
❑ Complete Medical Records
❑ Laboratory Results, specify types & date(s)___________________________________
❑ X-Ray and imaging reports, specify type & date(s)______________________________
❑ Other, specify __________________________
As per my request, reason for release of information:
❑ medical care ❑ legal ❑ insurance ❑ other (specify)_________________

This authorization is voluntary and I may cancel this consent to release information at anytime by sending written notice to Town Square Dermatology, 1100 6th St., Coralville, IA 52241. I understand that any release that was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Administrator of Town Square Dermatology at the above address. I understand that Town Square Dermatology may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

This agreement will expire one year from the date of the signature, unless previously revoked or otherwise indicated (specify number of days or months)_____________________________________

Signature of Patient or Legal Guardian____
Date:______________________

Complete Mailing Address/Street/PO Box____
City/State/Zip____

Witness Signature____