TOWN SQUARE
Dermatology
1100 Sixth Street, Suite 202 | Coralville, Iowa 52241 | (P) 319-337-4566 | (F) 319-337-4766

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM TOWN SQUARE DERMATOLOGY

Patient Name: _____

Date of Birth: _____ **Social Security Number:** _____

Provider: Town Square Dermatology
1100 Sixth Street, Suite 202
Coralville, IA 52241
319-337-4566

Send Records To:

Name: _____

Address: _____

Information Requested
_____Complete Medical Records _____Biopsy Reports
_____Lab Data _____Other_____

Purpose of Release
_____Transferring Medical Care _____Insurance Coverage
_____Moving _____Second Opinion
_____Personal File _____Other_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I specifically authorize the release of data and information relating to: (Check all that apply)

1. _____Substance abuse (Alcohol/Drug)
2. _____Mental Health (includes psychological testing)
3. _____HIV-related information (AIDS related testing)

I understand that these records may be mailed or faxed and I release this office from all responsibility or liability that may arise from this authorization.

The authorization is effective for 90 days from the date on which it is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Town Square Dermatology. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Town Square Dermatology.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT: _____ **WITNESS:** _____