TOWN SQUARE
Dermatology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
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)

This authorization for release of information covers all past, present, and future periods.

❑ This information is to be released **FROM:**	❑ This information is to be released **TO:**
Name:_____	Name:_____
Address:_____	Address:_____
Phone:_____	Phone:_____
Fax:_____	Fax:_____

❑ 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)_____

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)

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_____

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.