AUTHORIZATION TO RELEASE MEDICAL RECORDS

El Centro Dermatology & Laser Center

1334 N. Imperial Ave., El Centro, CA 92243

Phone: 760-337-8500 | Fax: 760-337-8572 | Email: hello@elcentrodermatology.com

Patient Name: _____ Date of Birth: _____ Phone Number: _____

I authorize the release of medical records:

[ ] FROM another provider/facility TO El Centro Dermatology

[ ] FROM El Centro Dermatology TO another provider/facility

Releasing Provider/Facility Name: _____

Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

Receiving Provider/Facility Name: _____

Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

Purpose of Release (check all that apply):

[ ] Continuity of care [ ] Insurance [ ] Legal [ ] Personal [ ] Other: _____

Information to be Released (check all that apply):

[ ] All medical records [ ] Office visit notes [ ] Lab/pathology results

[ ] Radiology/imaging reports [ ] Procedure/surgical reports [ ] Other: _____

I understand that:

- This authorization is valid for one year unless I revoke it in writing.
- I may revoke this authorization at any time in writing.
- Information disclosed under this authorization may be re-disclosed by the recipient.
- My treatment or payment is not conditioned on signing this form.

Signature of Patient or Legal Representative: _____ Date: _____

If not patient, Name and Relationship to Patient: _____