

TWIN CITIES DERMATOPATHOLOGY
Authorization for Release of Medical Information

PATIENT NAME (LAST, FIRST, MI.)	D.O.B	S.s.#
STREET ADDRESS		
CITY, STATE, ZIP		

PROVIDER:

<input type="checkbox"/> TWIN CITIES DERMATOPATHOLOGY 9909 SOUTH SHORE DRIVE, SUITE 2A PLYMOUTH, MN 55441 PH:(763)525-0363 Fax: (763)525-0369	<input type="checkbox"/> (OTHER) _____ _____ _____
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RELEASE TO:

<input type="checkbox"/> TWIN CITIES DERMATOPATHOLOGY 9909 SOUTH SHORE DRIVE, SUITE 2A PLYMOUTH, MN 55441 PH:(763)525-0363 Fax: (763)525-0369	<input type="checkbox"/> (OTHER) _____ _____ _____
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INFORMATION REQUESTED:

Pathology Report(s)
 Slide(s)
 Block(s)
 Other (Explain) _____
 Time Period (From/To) and/or Accession #(s):

For the purpose of:

Evaluation
 Treatment
 Placement
 Other (Explain) _____

INFORMATION RESTRICTIONS (List any restrictions on information to be released):

I give permission to the PROVIDER to release Medical Record Information to the specified party concerning the Medical Condition/Injury which was diagnosed/treated during the stated TIME PERIOD. The information released may include, but not be limited to that which involves treatment for alcohol or drug abuse; will be limited by any INFORMATION RESTRICTIONS outlined above; and may be used only for the purpose described.

I understand that this release will take effect on the date signed and will be in effect for one (1) year.

I understand that there may be a charge associated with the release of information for services rendered. There is no charge for release of information to other health care facilities.

I understand that I can cancel this release at any time by notifying the PROVIDED in writing and that my cancellation will take effect when the PROVIDER receives my written notice. I understand that my cancellation will not have any effect on information released before the PROVIDER received my written notice.

SIGNATURE OF PERSON AUTHORIZING RELEASE OF INFORMATION	DATE

IF NOT SIGNED BY PATIENT		INFORMATION SENT BY	
RELATIONSHIP TO PATIENT	REASON PATIENT UNABLE TO SIGN	NAME	DATE