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:

□ TWIN CITIES DERMATOPATHOLOGY
9909 SOUTH SHORE DRIVE, SUITE 2A
PLYMOUTH, MN 55441
PH:(763)525-0363 Fax: (763)525-0369

□ (OTHER)_____
_____
_____

RELEASE TO:

□ TWIN CITIES DERMATOPATHOLOGY
9909 SOUTH SHORE DRIVE, SUITE 2A
PLYMOUTH, MN 55441
PH:(763)525-0363 Fax: (763)525-0369

□ (OTHER)_____
_____
_____

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