WHITE ROCK DERMATOLOGY

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Not infrequently we are asked to provide information related to your care to your primary care physician and/or to your insurance carrier to resolve issues related to charges. Spouses and/or children frequently request the results of laboratory studies and biopsy reports. Without your authorization we cannot provide such basic information to anyone except you the patient. This simple form is to allow you to provide that authorization, or to specifically deny such authorization when appropriate.

I hereby authorize the release of information from my medical record to the following:

_____ Primary Care Physician
_____ Other Specialty Care Physician from whom I receive care
_____ Spouse
_____ Parents
_____ Children and their spouses
_____ Other (specify) _____

(Please check any of the above that you specifically wish to include.)

I understand that information released is for the purpose of providing quality continued patient care. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

May we leave medical information on your home answering machine if we are unable to reach you? YES NO (Please circle appropriate response)

Patient name_____ Date of Birth_____

_____ _____

Signature of Patient or Legal Representative Date

Parent or Legal Guardian must sign for patient Under 18 years of age.

_____ _____

Relationship to Patient if other than self Witness

PLEASE SIGN

SO WE HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes that I am responsible for all charges. I authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical benefits to which I am entitled to White Rock Dermatology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Signature:_____ Date:_____