Cleaver Dermatology
1316 Country Club Drive · PO Box 7545 · Kirksville, MO 63501
PH: (660) 627-7546 · Fax: (660) 956-7097

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS INFORMATION

PATIENT INFORMATION: (Please Print – Must be completed in ink)

_____

Patient Name | Date of Birth | SSN

_____(_____)_____

Address | City | State | Zip | Phone #

RELEASE FROM: (Name of Physician or Facility releasing information)

I authorize release of my medical records from:

_____(_____)_____

Physician/Facility | Phone #

_____(_____)_____

Address | City | State | Zip | Fax #

RELEASE TO: (Name of Physician or Facility receiving information)

Please send my medical records to:

_____(_____)_____

Physician/Facility | Phone #

_____(_____)_____

Address | City | State | Zip | Fax #

RELEASE INFORMATION:

Reason: ❑ Change of Insurance ❑ Transfer of Care ❑ Personal File
❑ Moving out of area ❑ Specialist Consult ❑ Legal

Please Release the following: (Check all that apply)
❑ Entire Record ❑ Lab/Pathology Results Only ❑ X-Ray Reports

❑ Last visits (dates) _____

❑ Other (please specify) _____

CONSENT:

I understand the Authorization may be revoked by written notice by myself at any time. Unless otherwise stated, this authorization will be in effect for one year past the date signed below. I understand that I may inspect and copy any written correspondence released to the above party. A photocopy of this authorization shall be fully effective and as valid for all purpose as the original hereof. I understand that once my PHI has been release it may not be covered under the Privacy rule of Cleaver Dermatology.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Witness) (Date)