Medical Records Request

Patient Name: ______________________________________ DOB: ______________________

Address: ______________________________________ Telephone: ______________________

I hereby authorize and request the release of the following records:

_____ To _____ From

West Omaha Dermatology, LLC

_____ To _____ From

Name: ______________________________________

Address: ______________________________________

City, State, Zip: ______________________________________

Dates of service to be included:

_______ / _______ / _______ to _______ / _______ / _______

Records to be included:

[ ] Lab Reports

[ ] Pathology Reports

[ ] Radiology Reports

[ ] Clinic Notes

[ ] Complete Record

Purpose of the release: ____

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to West Omaha Dermatology, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that West Omaha Dermatology, LLC will not condition the provision of treatment or payment on the provision of this authorization.

This authorization expires in 6 months.

A photocopy of this agreement shall be as valid as the original.

Patient Name [please print]: ____

Patient/Guardian Signature: ____

Date: ____

Relationship to Patient: ____