THE DERMATOLOGY CENTER at Ladera

600 Corporate Drive, Suite 240
Ladera Ranch CA 92694-2111
Phone: 949-364-8411
Fax: 949-364-8511

Medical Record Release Authorization

Patient Name:_____ Maiden/Other Name(s):_____

Date of Birth:_____ Phone #:_____

I hereby authorize the release of my records as specified below.

1. Release records FROM

Check one box.

☐ **The Dermatology Center at Ladera**

☐ **Other,** specify doctor, organization, or individual (complete each line below)

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

2. Send records TO

Check one box.

☐ **The Dermatology Center at Ladera**

☐ **Other,** specify doctor, organization, or individual (complete each line below)

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

3. For the purpose of

☐ Transfer or Continuity of Care
☐ Self/Personal Copy
☐ Insurance
☐ Disability
☐ Workers Comp
☐ Litigation
☐ Other

4. Records to be released

Date Range: _____ to _____

☐ Pathology Reports
☐ Lab Reports
☐ Physician Office Notes
☐ Operative/Procedure Reports
☐ Last year of treatment
☐ Other _____

Signing this authorization is voluntary and not required to obtain treatment. Any disclosure of information may lead to unauthorized re-disclosure, and the information may no longer be protected by federal confidentiality laws. If I have questions about the disclosure of my health information, I can contact the individual or organization making the disclosure.

My medical records may include sensitive information relating to sexually transmitted diseases, HIV/AIDS, mental health, substance abuse treatment, and cosmetic services.

This authorization will expire 1 year from the date below unless I specify otherwise. I can revoke this authorization at any time for future disclosures by submitting a written request. Fees may apply for certain record requests, in accordance with applicable law.

I have read and understood the terms of this form and I consent to the disclosure as outlined above.

✘ _____ _____

*Signature of **Patient (or Parent/Guardian/Authorized Representative)*** *Date*

For Office Use Only

Request Fulfilled (Date/Time):_____ Method: _____ Staff Initials:_____