Scenic Dermatology

Authorization for Release of Medical Information

Scenic Dermatology
1200 Chaska Creek Way, Ste. 220
Chaska, MN 55318
P: 952-520-5000 F: 952-520-5001

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip code: _____

Patient Phone #: ( ) _____ Today's Date: _____ Date Needed: _____

☐ I authorize Scenic Dermatology **to RELEASE information TO:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (with area code)

OR

☐ I authorize Scenic Dermatology **to OBTAIN information FROM:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (with area code)

FAX or BRING
this form to
Scenic Dermatology
(952) 520-5001

PURPOSE FOR THIS REQUEST: (check one) ☐ Personal ☐ Healthcare ☐ Insurance ☐ Transfer Care ☐ Other

TYPE OF RECORDS REQUESTED: (check one)

☐ All records at Scenic Dermatology **OR** _____

☐ All records related to a specific illness or injury

_____ _____
Specific Illness/Injury Date(s) of treatment

☐ Specific information (Select one or more, as applicable)

☐ Procedure Report ☐ History & Physical ☐ Pathology Results ☐ Laboratory Test Results

☐ Billing Summary ☐ Other _____
(Please describe)

AUTHORIZATION VALID FOR: (check one)

☐ This request only

☐ One year from this date of this authorization **OR** _____ (Insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request and for records of any future treatment of the type described above until: _____
Insert date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requester is not the patient): _____

Created: 03/2025