AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Regarding patient:

Name (last, first, MI)	Date of Birth
Street Address	Social Security Number
City/State/Zip	Daytime phone number

Information Released FROM:	Released TO:
Skin Care Doctors, P.A. Name (Clinic, Physician)	Name (Clinic, Physician)
14000 Nicollet Avenue South, Suite 304 Street Address	Street Address
Burnsville, MN 55337 952-898-2645 City/State/Zip Fax	City/State/Zip Fax

Type or extent of information to be disclosed (check applicable category):

- □ Records pertaining to:_____
  (Specific dates or conditions)
- □ Entire patient record

Purpose of need for disclosure (check applicable category):

- _____Personal
- _____Consult/Continuing care
- _____Selected new physician/clinic: reason why:_____
- _____Changed insurance plan
- _____Insurance/application claim
- _____Moved out of town
- _____Other:_____

All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/AIDS-related illness will be released unless otherwise indicated here in writing:

_____

_____

This authorization will remain in effect for one year and will automatically expire without my express revocation. I understand that I may cancel this request with written notification but that it will not have any effect on information released prior to notification of cancellation.

I authorize release of my medical records in accordance with specifications listed above:

Signature of Patient/Guardian	Relationship to Patient
Date of Patient's Signature	Reason Patient Unable to Sign