LUMA
DERMATOLOGY

# Medical Records Release

Patient Name: _____D.O.B _____

Address: _____

Phone: _____

I herein authorize/consent to disclose/release the following information:

☐ Complete Medical Record

☐ Biopsy Report(s)

☐ Lab Report (s) `

☐ Consultation Reports

☐ Medication List

☐ Surgical Procedures

For dates of service from _____ to _____.

***I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ***

| Records requested from: | Records disclosed to: |
|---|---|
| Name of Person/Facility: | Name of Person/Facility: |
| Practice Address: | Practice Address: |
| Phone: | Phone: |
| Fax: | Fax: |

***** Please be aware that a reasonable cost-based fee of $25.00 for copies of medical records may apply. Once the request is processed, the requestor will receive an invoice to submit payment. ****

***CHECKS MUST BE PAYABLE TO: LUMA DERMATOLOGY***

I understand I may 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 Luma Dermatology. I understand the revocation will not apply to information that has already been released in response to this authorization.

**Unless otherwise revoked, this authorization will expire 1 year from the date signed.**

Patient signature: _____ Date: _____