SUTTON
DERMATOLOGY + AESTHETICS

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Board Certified Dermatologists

Release of Medical Information

_____ _____
Patient Name (Print) Medical Record Number Patient DOB

_____I authorize Sutton Dermatology + Aesthetics to **release** / **receive** *(circle one)* my health information as described below.

To / From *(circle one)*:_____

Address_____State_____Zip_____

Fax#:_____Phone#:_____

Please release only the following information to **Sutton Dermatology + Aesthetics: 1710 S. 70th Street Lincoln, NE 68506**

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Records from last _____years
- ☐ Dr. Letter only-Date_____
- ☐ OP Report Dates_____
- ☐ Diagnostic Reports_____
- Consultation reports (please supply doctors' names): _____
- ☐ Other (please describe):

_____

The identified information will be used for the following purpose:

☐ My personal records
☐ Sharing with other health care providers as needed
☐ Other (please describe):

_____

Please initial each item below to indicate your understanding.

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

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

_____ _____/_____/_____
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

This Authorization expires one year from date signed.

Sender_____Date_____