Alta Dermatology

For the health and beauty of your skin

Patient Name: _____ DOB: _____/_____/_____

Address: _____

Phone: _____

Release From: _____ Release to: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Address: _____ Address: _____

_____ _____

Records Requested:

X-ray Report(s) ☐		**Copy of Films/Imaging Study** ☐	
Laboratory Reports ☐		**Diagnostic Studies** ☐	
Progress Notes ☐		**Consultation(s)** ☐	
All ☐	**Other** ☐	_____	

Date of records requested: From: _____ To: _____

Records shall be used for: Acute care ☐ Continuation of care ☐ Second opinion ☐

Records shall be delivered by: Fax ☐ U.S. Mail ☐ Other ☐ _____

This consent is valid for 30 days from the date signed.

I hereby authorize "Release From" as stated above, to deliver to "Release To" as stated above the medical records as defined above by my indicated check marks. I, the patient or patient's representative, have the legal right to inspect, copy, and request delivery as specified of this Protected Health Information within the next 30 days in accordance with Public Law 104-191 (HIPAA-1996). I accept the responsibility for any fees that may be associated with this request.

Patient Signature: _____ Date: _____/_____/_____

Patient's Legal Representative: _____ Date: _____/_____/_____

Printed name of Legal Representative: _____