CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____
City/State/Zip code: _____
SSN#: _____Phone: _____ Fax: _____

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates:
  _____
  _____
- ☐ Billing History
- ☐ All healthcare information
- ☐ Other: _____

RELEASE: I request and authorize Contour Dermatology & Cosmetic Surgery Center to RELEASE health care information of the patient named above to:

☐ Personal Records (Please circle one): Mailed or Faxed or Pick up

☐ Physician's Office: _____

Phone: _____ Fax: _____

OBTAIN: I request and authorize Contour Dermatology & Cosmetic Surgery Center to OBTAIN health care information of the patient named above from:

☐ Physician's Office: _____

Phone: _____Fax: _____

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, expect where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information required additional authorization.
- If it is more than 35 pages, there will be a $35.00 fee before records can only be picked up or mailed (not faxed).
- This release authorizes the disclosure of records for one year from the date signed above.
- May take 5-7 business days to be processed and available.

Patient Signature: _____ Date Signed: _____