Krauss Dermatology
1Washington Street, Suite 401
Wellesley Hills, MA 02481
Phone: (781) 416-3500 Fax: (781) 416-3505

Authorization to Release Medical Records

Patient Name: _____ D.O.B:_____

Patient Address: _____

Authorizes: Krauss Dermatology, P.C.
1 Washington Street, Suite 401
Wellesley Hills, MA 02481

to release to: _____
Name of Physician, Practice

_____
Address of Physician, Practice

Purpose of disclosure:

☐Medical Care ☐Insurance ☐Legal ☐Transferring care ☐ Other

The information to be released is:

☐ Complete medical records including patient histories, office notes (except psychotherapy notes) test results, radiology studies, referrals, consults.

Other: _____

Include(Indicate by initialing):

____ Medical Records for dates: _____

____ Biopsy and Lab Reports

_____Surgical procedures

____ Other (please specify):_____

Duration and revocation:

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____. You or your Personal Representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

Additional Information:

Fees: Patient requesting record: $25.00 Release to physician office: no charge
Insurance company/Attorney/ Certified Medical Record: $35.00
Please mail this completed form along with your payment to Krauss Dermatology at above address.

When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_____ _____
Signature of patient or representative Date

If not signed by patient:

This authorization was signed by:

_____Date_____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____