King Dermatology

675 Hwy 62 E., Ste 1
PO Box 763
Mountain Home, AR 72653
Phone: (870) 425-5464 Fax: (870) 425-5465

Authorization for Release of Medical Records

Patient Information
Name: __________________________________ **DOB :**___/__/____
Phone: (____)____-_____ **Cell:**(____)____-_____

Address: ______________________________________ **City:**____________________
State: ____ **Zip Code:**_______

I Authorize King Dermatology to:

Obtain my Pathology report(s) (ex. Another doctor) ______
Release my Medical Records (ex. Another doctor) ______

Name of Physician/Facility:___________________________ Phone:(___)___-____
Address :__________________________________ Fax:(___)___-_____
____

Name of Physician/Facility :___________________________ Phone:(___)___-____
Address :__________________________________ Fax:(___)___-_____
____

Name of Physician/Facility :___________________________ Phone:(___)___-____
Address: __________________________________ Fax:(___)___-_____
____

This Authorization will remain in effect indefinitely or until the following date:___/___/_____

I understand that I have the right to:

> Revoke this authorization at any time. I understand that I order to revoke this authorization, I must do so in writing and send my written revocation to King Dermatology. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to King Dermatology when the law provides its right to contest a claim number under my policy.

> I understand that I do not have to sign this authorization and that King Dermatology may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign the form.

> I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

> Right to Copy/Voluntary Disclosure: I know that I have the right to receive a copy of this authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

Signature of Patient:____
Representative/POA:____
Do I have paperwork for POA on file?_______ or Attached?_______
Date:____________________