Sound Dermatology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Sound Dermatology, LLC
Owner/Clinical Director: Joshua Schell, APRN
State: Kansas

Phone: _____ Fax: _____
Address: _____

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____
Phone: _____
Address: _____

AUTHORIZATION

I authorize (check one or both):

☐ **Sound Dermatology, LLC** to ***release*** my medical records to:
Name/Facility: _____
Address: _____
Phone: _____ Fax: _____

☐ **Sound Dermatology, LLC** to ***obtain*** my medical records from:
Name/Facility: _____
Address: _____
Phone: _____ Fax: _____

RECORDS REQUESTED (Check all that apply)

☐ Complete medical record
☐ Office visit notes
☐ Pathology reports
☐ Procedure notes
☐ Medication history
☐ Billing records
☐ Other: _____

Date Range (if applicable): From: _____ To: _____

Sound Dermatology

PURPOSE OF DISCLOSURE (Optional)

☐ Continuity of care
☐ Personal use
☐ Insurance
☐ Legal
☐ Other: _____

SENSITIVE INFORMATION

This authorization includes release of information related to mental health, substance use treatment, HIV/AIDS status, and sexually transmitted infections, if present in the record.

EXPIRATION

This authorization expires (check one):

☐ 90 days from signature
☐ One year from signature
☐ On this date: _____
☐ Upon completion of this request

I understand:

- I may revoke this authorization in writing at any time, except to the extent action has already been taken.
- Treatment, payment, or eligibility for benefits is not conditioned on signing this form.
- Information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

Patient/Legal Representative Signature:_____Date: _____

Printed Name: _____

If signed by representative, authority: _____

FOR OFFICE USE ONLY

Date Received: _____
Identity Verified: ☐ Yes ☐ No
Method of Release: ☐ Fax ☐ Secure Email ☐ Mail ☐ Portal ☐ In-Person
Processed By: _____ Date: _____

HIPAA-Compliant Authorization (45 CFR §164.508)