

## DERMATOLOGY MEDICAL RECORDS RELEASE AUTHORIZATION

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### Patient Information

- Patient Full Name: \_\_\_\_\_
  - Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  - Phone Number: \_\_\_\_\_
  - Email Address: \_\_\_\_\_
  - Address: \_\_\_\_\_  
\_\_\_\_\_
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### Authorizing Provider

**Physician:** Dr. Kaveri Karhade, MD  
**Address:** 2100 Webster Street, Suite 505  
San Francisco, CA 94115  
**Phone:** (415) 923-3377 **Fax:** (415) 923-3277

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### Records to Be Released

**All medical records**, including but not limited to:

- Dermatology office visit notes
- Diagnoses and treatment records
- Pathology reports and biopsy results
- Laboratory reports
- Prescriptions and medication history
- Clinical photographs (if applicable)

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- Billing records related to care

Records from dates of service: \_\_\_\_\_

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## Release To (Recipient)

- Patient (self)
- Another healthcare provider
- Attorney / insurance / other

**Name / Organization:** \_\_\_\_\_

**Address:** \_\_\_\_\_

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**Phone / Fax / Email:** \_\_\_\_\_

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## Purpose of Disclosure

- Personal use
  - Continuity of care
  - Insurance / billing
  - Legal
  - Other: \_\_\_\_\_
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## Expiration of Authorization

This authorization will expire:

- One (1) year from the date signed**, unless otherwise specified
  - On the following date or event: \_\_\_\_\_
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## Patient Rights & Acknowledgment

- I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken.
- I understand that information disclosed under this authorization may be subject to re-disclosure and may no longer be protected by HIPAA.

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- I understand that my treatment will not be conditioned on signing this authorization.
  - I authorize the release of my protected health information as described above.
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## Signature

Patient / Legal Representative Name: \_\_\_\_\_

Relationship to Patient (if applicable): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## Office Use Only

- Identity verified
- Copy of ID received
- Records released on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Method:  Fax  Mail  Secure Email  Portal
- **Processed by:** \_\_\_\_\_