

## PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

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FAAD, ACMS

**Frederick Fish, MD**  
FAAD, FACP, ACMS

**Jeffrey Freed, MD**  
FAAD

**Holly Hanson, MD, MHA**  
FAAD

**Jamie Hanson, MD**  
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**Ngo Hien, MD**  
(in memoriam)

**Steven Kempers, MD**  
FAAD

**Bailey Lee, MD**  
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**Jane Lindholm, MD**  
FAAD, FASDP

**Jane Lisko, MD**  
FAAD, ACMS

**Erin Luxenberg, MD**  
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**J. Daniel Mischke, MD**  
FAAD

**Anne Nikle, MD**  
FAAD

**Soheil Pakzad, MD**  
FAAD

**Scott Prawer, MD, MS**  
FAAD

**Marki Swick, MD**  
FAAD

**Roger Weenig, MD**  
FAAD, FASDP

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Release my records from:**

\_\_\_\_\_  
(Facility Name)

**Release the records to:**

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
Fax Number (For patient care only)

**Please release the following:**

\_\_\_\_ Last Visit and Corresponding Pathology Report(s)

\_\_\_\_ Current Medical Record (we will release 1 year's worth of most recent records)

\_\_\_\_ Pathology Report(s) only      \_\_\_\_ Maps/Picture(s)      \_\_\_\_ Lab(s)

\_\_\_\_ Other (please specify dates): \_\_\_\_\_

All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released. Please initial here if you **DO NOT** authorize these records to be released: \_\_\_\_\_

**For the following purpose(s):**

\_\_\_\_ Personal Record

\_\_\_\_ Continuing Care

\_\_\_\_ Consult

\_\_\_\_ Insurance Claim

\_\_\_\_ Insurance Application

\_\_\_\_ Seeing other provider

\_\_\_\_ Other \_\_\_\_\_

This authorization will end one year from the date signed. I understand that I may revoke this authorization in writing at any time. A copy of this authorization will be treated in the same way as the original. Associated Skin Care Specialists cannot prevent redisclosure of your information by the entity who receives your records under this authorization and your information may no longer be protected by the Federal HIPAA Privacy Rule after release. By signing, I authorize the named above to use and/or disclose certain protected health information (PHI).

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authority to act on behalf of patient (attach document)

**New Brighton -  
Administrative Office**  
119 - 14th Street NW  
Suite 240  
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**Blaine**  
11107 Ulysses Street NE  
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Blaine, MN 55434

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500 Osborne Rd NE  
Suite 330  
Fridley, MN 55432

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Suite 280  
Coon Rapids, MN 55433

**Eden Prairie**  
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Maple Grove, MN 55369

**Minneapolis - Linden Hills**  
4279 Sheridan Ave S  
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