Associated Skin Care Specialists

BOARD CERTIFIED DERMATOLOGISTS

Medical Dermatology
Mohs Surgery
Research
Cosmetic Services
Dermatopathology

Bart Endrizzi, MD, PhD FAAD, ACMS
Frederick Fish, MD FAAD, FACP, ACMS
Jeffrey Freed, MD FAAD
Holly Hanson, MD, MHA FAAD
Ngo Hien, MD (in memoriam)
Susan Humphreys, MD FAAD
Steven Kempers, MD FAAD
Bailey Lee, MD FAAD
Jane Lindholm, MD FAAD, FASDP
Jane Lisko, MD FAAD, ACMS
Ann McGinn, MD FCAP, FASDP
J. Daniel Mischke, MD FAAD
Ann Norland, MD FAAD
Soheil Pakzad, MD FAAD
Scott Prawer, MD, MS FAAD
Steven Prawer, MD FAAD
Erika Rabeni, MD FAAD, FASDP
Jeffrey Squires, MD FAAD, ACMS
Roger Weenig, MD FAAD, FASDP

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Date:________________

I authorize ____to use and/or disclose certain protected health information (PHI) about :

Patient Name:______________________________________ Date of Birth:_____________

Please release the records to: ____
(Name)

____
(Address)

____
(City,State,Zip)

____
Fax Number (For patient care only)

Please release the following:

___ Entire Medical Record ___ Lab(s) ___ Special Test(s)
___ Maps/Picture(s) ___ Billing Statements(s)
___ Other please specify:____

All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by your signature here: ____

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.

____ ________________
Signature of Patient or Legal Representative Date

____
Authority to act on behalf of patient (attach document)

Fridley – Main Office
7205 University Ave NE
Fridley, MN 55432

Fridley – Unity
500 Osborne Rd NE
Suite 330
Fridley, MN 55432

Coon Rapids
3833 Coon Rapids Blvd
Suite 280
Coon Rapids, MN 55433

Eden Prairie
18315 Cascade Dr
Suite 150
Eden Prairie, MN 55347

Maple Grove
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