



CLEAR DERMATOLOGY



Malcolm S. Ke, MD
Mohs Micrographic Surgery · Facial Reconstruction

MEDICAL RECORDS – RELEASE OR ACQUISITION

Without your written consent, we are not able to release or obtain records from other providers.

I authorize Clear Dermatology to: Obtain My Records Release My Medical Records

Name of practice, facility or provider: _____

Patient Name: _____ DOB: _____

Fax Number: _____

Type of information to be released or obtained:

- | | |
|---|---|
| <input type="checkbox"/> Billing Statements | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Other: _____ |

Specify the date or time period for information selected above: _____

The purpose of this release is:

- At the request of the patient/patient representative
- Other (state reason) _____

NOTICE:

We are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS:

- I understand this authorization is voluntary.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to Clear Dermatology, 23456 Hawthorne Blvd. Suite 100, Torrance, CA 90505. The revocation will take effect when we receive it.
- I am entitled to receive a copy of this Authorization.

Expiration of Authorization:

Unless otherwise revoked, this Authorization expires (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

Signature: _____ Date: _____

(Signature of Patient or Legal Guardian)

Name of Guardian: _____ Relationship: _____

Phone Number: _____ Witness: _____