Gary L. Heller, D.O.
Dermatology | Research | Cosmetic Center

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Authorization for Release of Medical Information

Patients Name: _____ **Date of Birth:** _____

Address: _____

City/State/ Zip code: _____

SS# _____ **Patient's Phone #** (_____)_____

Date of Request: _____ **Date Needed:** _____

☐ **I authorize Gary L. Heller, D.O. to release information to:**	**OR**	☐ **I authorize Gary L. Heller, D.O. to obtain information from:**
Name of Provider or Facility		Name of Provider or Facility
Address		Address
City, State, Zip Code		City, State, Zip Code
Phone # / Fax #		Phone #/ Fax # (Include area code)

PURPOSE FOR THIS REQUEST: (Check one) ☐Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other
☐ Transfer of care

TYPE OF RECORDS REQUESTED: (Check one)

☐ Immunization history.

☐ All Medical Records Related to a Specific Illness or Injury.

_____

specify illness/ injury **Date(s) of treatment**

☐ Treatment summary (Includes history/physical, laboratory test & x-ray reports, operative reports, pathology)

☐Specific information (Select one or more, as applicable)

☐ Procedure Report ☐ History and Physical ☐ Physical Therapy ☐ Laboratory Test Results

☐ X Ray reports ☐ Other (please describe) _____

☐ Copy of the entire medical record, as allowed by law.

AUTHORIZATION VALID FOR: (Check one)

☐ This request only.

☐ One year from the date of this authorization, **OR** _____(insert date) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request **AND** for medical records of any **future** treatment of the type describe above until: _____
Insert date

I understand that:

- My right to healthcare treatment is not conditioned to this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Released of HIV-related information, mental health related care, or substance abuse diagnosis and treatment requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in case of medical necessity only.

Signature of Patient/ Representative_____ Date: _____