Helix Dermatology & Skin Surgery Institute

3690 Orange Place | Beachwood, Ohio | 44122 | Phone: 440 - 794 - 0004 | Fax: 440 - 499 – 6886

AUTHORIZATION FOR USE OF DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient information:

Name: _____ DOB: _____/_____/_____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Release Information To (check one):

- ☐ *I hereby authorize **Dr. Olga Demidova** to release my medical record information to the physician or facility listed below.*
- ☐ *I hereby authorize the physician or facility listed below to release my medical information to **Dr. Olga Demidova.***
- ☐ *I hereby request and authorize **Dr. Olga Demidova** to release my medical records to myself and/ or family member listed below.*

Name/ Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Delivery Preference (check one):

- ☐ Mail copies to address listed above
- ☐ Hold for patient pick- up
- ☐ Fax: _____

Information To be Released (check one):

- ☐ Progress notes only
- ☐ Pathology reports only
- ☐ Other (specify records needed): _____
- ☐ Laboratory Notes only
- ☐ All Records

Purpose for Need or Disclosure (check one):

- ☐ Continued Patient Care
- ☐ Attorney/ Legal
- ☐ Other: _____
- ☐ Insurance Claim/ Application
- ☐ Change of Physician/ Relocation

I understand that the information release is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any employee of Dr. Olga Demidova for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

_____ _____ _____

Patient Signature | Relationship to Patient (self, parent, spouse) | Date

Please fax completed form or mail to address below, attention Medical Records.

3690 Orange Place Suite 300 | Beachwood, Ohio 44122

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For Office Use Only. Staff Initial: _____ Date/ Time Handled: _____ Means of Transmittal: _____