F|D FARGO CENTER FOR DERMATOLOGY
MEDICAL | SURGICAL | AESTHETIC

(P) 701-478-8780 (F) 701-478-8781
www.fargoderm.com

Authorization for Release of Medical Information

Patient Name: _____ Maiden (Other) Name: _____

DOB: _____

Address: _____

City/State/Zip: _____

I authorize Fargo Center for Dermatology to:

☐ Send copies of your record to (or discuss information with) the provider/person/facility below

OR

☐ Receive copies of your medical record from (or discuss your information with) the provider/person/facility below.

Name of Provider: _____

Address: _____

City/State/Zip: _____

Phone: (____) _____

Information to be disclosed: ☐ Progress Notes ☐ Pathology/Lab Report(s) ☐ Operative Notes ☐ Cosmetic Notes ☐ Entire Medical Record

Fax: (____) _____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. There may be a charge for the requested records according to ND State Law (Century Code 23-12-14). The records above may be faxed in case of medical necessity. This authorization may be cancelled at anytime by submitting a written request to Fargo Center for Dermatology.

I have read the above Authorization for release of medical information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature: _____ Date: _____
Parent or Guardian signature required for any patient under the age of 18

Relationship to Patient (if other than self): _____

Printed Name of Representative: _____

This authorization will remain in effect until we have written notice of cancellation.