CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

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Request for Release of Medical Records

Patient Information:

Name: _____
Date of Birth: _____
Phone Number: (_____) _____

Records Requesting: ☐ Entire Chart ☐ Recent Labs/Pathology ☐ Other: _____

Reason for Record Release:

- ☐ Relocating from the Coachella Valley Area
- ☐ Personal Records
- ☐ Sending copies of medical records to primary physician or insurance provider
- ☐ Leaving Contour Dermatology for a new Dermatologist in the area (please explain further below):
  - Why are you choosing to leave our practice? _____
    _____
  - Who referred you to this new Dermatologist? _____
  - Is there anything we could do to keep you as a loyal patient? _____

Records being sent to:

- ☐ **Patient**
  - **Mailing Address:** _____
  - **Fax:** _____
  - **Email:** _____
  - **Pick up in office** (circle which office): Rancho Mirage or Palm Springs
- ☐ **Physician Office**
  Name of Doctor: _____
  Phone: (_____) _____ Fax: (_____) _____
  Address: _____
  City: _____ State: _____ Zip: _____
- ☐ **Other (please specify)** _____

By signing this document as Contour Dermatology's patient, I, _____ understand that my right to healthcare is not conditioned on this authroization. I am also aware that it is my right to cancel this authorization at any time by submitting a written request to Contour Dermatology, except where a disclosure has already been made in reliance on my prior authorization. I understand that if I am requesting my records to be sent to a person or faciltity that is not a health care of medical isnruance porvider covered by privacy regulations, the information stated above could be re-disclosed. Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information will require a specific and additional authorization. If the medical records requested is more than 35 pages, there will be a $24.00 fee before records can be picked up or mailed, for fax will not be an option. If photos are requested on a CD/DVD format, there will be a $25.00 fee at time of pick up. As the patient I understand that this release authroizes the disclosure of records for one year from the date signed below and may take up to 5-7 business days to be processed and available.

Patient Signature: _____ Date Signed: _____