MOD
DERMATOLOGY

Authorization for Release of Health Information

Patient Name: _____ D.O.B. _____

Address: _____

Phone # _____

I hereby authorize _____to disclose my health information as follows:

( ) Check here if disclosure is at the request of the individual
Disclose ( ) To ( ) From (Please check one)

Name: _____

Address: _____

City, State and Zip: _____

Information to be disclosed: (check all that apply)

( ) History and Physical Exam	( ) Consultation Report	( ) Imaging Reports
( ) Lab Reports	( ) Progress Notes	( ) Complete Record

Dates of service or time period of records to be disclosed: _____
(state time period or "all")

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at MOD Dermatology, PC.

2. Medical information to be disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by State or federal law.

3. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to MOD Dermatology. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.

4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Signature of patient or patient's personal representative Date

_____
Relationship to patient if signed by personal representative

Melanie Ortleb, MD, FAAD
Board Certified in Dermatology and
Micrographic Dermatologic Surgery
Gage Rensch, MD, FAAD
Board Certified in Dermatology and
Micrographic Dermatologic Surgery

Amy K. Price, PA-C
Mary Otteman, PA-C
Amanda Strudthoff, PA-C
Jennifer Keenan, PA-C

16910 Frances Street
Omaha, Nebraska 68130
Phone: 402-505-8777
Fax: 402-933-7767
www.moddermatology.com