AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____

Patient Name (printed) Date of Birth

I hereby authorize the following health care professional, medical facility, or medical records service to release my medical information:

Person/Organization to Release Information: _____

Address (Street/City/State/Zip Code): _____

Phone # _____ Fax # _____

Medical Information Requested:

[ ] All Records

[ ] Specific Records from _____ to _____

The following person/organization is hereby authorized to receive my medical record, treatment record, and diagnostic record:

Person to Receive Information: **Resolute Dermatology**

Daniel Christiansen, MD_____ Elizabeth Spenceri, MD_____

Judy Ky, PA-C_____ Megan Cummings, PA-C_____

_____ Address: 12850 Metcalf Ave, Suite 210, Overland Park, KS 66213 P: 913-951-0044

_____ Address: 6800 Hilltop Rd, Suite 102, Shawnee, KS 66226 P: 913-901-5051

Fax #: (913) 901-5051 (for both offices)

_____ _____

Signature of Patient or Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.