SKIN REHAB
DERMATOLOGY / AESTHETICS
15 East 7th Street
Grafton, ND 58237
info@theskinrehab.com
P: 701.379.0140 / F: 701.379.0145

Two way Authorization to Release Confidential Health Information

Patient Name:		Date of Birth:	

I hereby authorize the following medical information to be released between:

EPIC	AND	Skin Rehab 15 E. 7th St. Grafton, ND 58237

The specific health information to be released/exchanged is (check all that apply):

	Complete Medical Record
	Other:_____

Skin Rehab wants you to be aware of the potential that this information, once forwarded to the other party, could be re-disclosed and no longer protected.

This requested information is to be used for the purpose of Continuity of Care.

I understand that this consent may be revoked at any time by requesting a Revocation of Two-Way Authorization form. In any event, if not previously revoked, this consent will expire one year from the signature date.

Parent/Guardian Name (please print):		Date:	
Parent/Guardian Signature:		Date:	
Relationship to Patient:		Date:	

NOTE: A photocopy or fax of this signed release form is as valid as the original