# Medical Records Request

**To:** _____

_____

_____

_____

From: Greater Des Moines Dermatology PC

Timothy Abrahamson, MD

2424 128th St

Urbandale, IA 50323

Tel: 515-243-8676 Fax: 515-243-0487

I request a copy or summary of the following medical records:

**Patient Name:** _____ DOB:_____

_____Complete Medical Record excluding mental health treatment, drug/alcohol abuse, HIV information, AIDS which are protected by federal and state law

_____Biopsy Reports _____Lab Reports _____Consultation Reports

_____Medication Allergies _____Allergy Test/Treatment _____Surgical Procedures

Other: _____

Special Request: (Circle ALL that apply)

Mental health treatment, Drug/alcohol abuse, HIV information, HIV testing, Other: _____

For dates of service from_____to _____

Additional Comments:

_____

Patient Signature: _____ Date: _____

Patient Guardian (if applicable): _____ Date: _____

Witness: _____ Date: _____

*This form does not authorize re-disclosure of medical information beyond the limits of the explicit request/consent above. Information from records protected by federal law or state law and/or not explicitly requested; these items should not be further disclosed without specific consent of the patient or patient's guardian. Civil and or Criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health information, and other medical information not directly requested.

This authorization is good for _____ months, but no longer than 1 year. This authorization may be revoked at any time by the signee upon receipt to the recipient of the authorization rescinding the request. I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate condition established by Greater Des Moines Dermatology PC.