



Crutchfield Dermatology

*"Look Good, Feel Great
with Beautiful Skin"*

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Diplomate, American Board of Dermatology
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Clinical Associate Professor of Dermatology
at the University of Minnesota
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General Dermatology

- Acne
- Psoriasis
- Skin Cancer
- Mole Checks
- Skin Exams
- Warts
- Rashes
- Pediatrics
- Skin Surgery
- Ethnic Skin
- Vitiligo

Laser Surgery

- Acne
- Birthmarks (Port Wine)
- Warts
- Unwanted Hair
- Facial Veins
- Sun Damaged Skin
- Age Spots
- Wrinkles
- Pixel Laser for Acne scars
and fine lines

Phototherapy Center

- Psoriasis
- Vitiligo
- Atopic Dermatitis
- Eczema
- Pruritus

Cosmetic Dermatology

- Botox Cosmetic
- Restylane • Juvederm • Perlane
- Laser Treatments
- DermiSpa
- Skin Rejuvenation Programs
- Peels
- Javani Facials
- Microdermabrasion
- Wrinkle Treatments
- Lipodissolve Ultra
- Mesotherapy
- AFT Photo Facials

1185 Town Centre Drive
Suite 101
Eagan, Minnesota 55123

Appointments: 651.209.3600
Fax: 651.209.3601

www.CrutchfieldDermatology.com

Authorization for Release of Medical Information

Patient Information:

Name: _____ Date of Birth: ___/___/___
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Phone: () _____ - _____

Type of Information Requested:

- Office Visit Notes Pathology Reports
 Lab reports / Blood Tests
 Other _____

Information to be released from:

Physician & Clinic Name: Crutchfield Dermatology
 Street Address: 1185 Town Centre Dr #101
 City: Eagan State: MN Zip: 55125
 Phone: (651) 209-3600 Fax: (651) 209-3601

Information to be received by:

Physician & Clinic Name: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Phone: () _____ - _____ Fax: () _____ - _____

Information to be released for the following reason:

- Personal Record Transfer of Care Consult
 Copy for my Primary Care Doctor Insurance Claim
 Other _____

The following items must be checked (✓) **and initialed** if you would like these items included in the use and disclosure of other health information.

Again, please check and initial on the lines near the items you would like included:

- ____ HIV/AIDS related information and/or records
 ____ Mental Health information and/or records
 ____ Genetic testing information and/or records
 ____ Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)

Describe: _____

Patient Signature _____ Date _____

Witness _____ Date _____